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ISSUES RELATED TO MEDICARE CONTRACTING

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HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

APRIL 22, 1986

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ISSUES RELATED TO MEDICARE CONTRACTING

TUESDAY, APRIL 22, 1986

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:40 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

[For immediate release Friday, Apr. 11, 1986]

Hon. Fortney H. (Pete) Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, Announces a Hearing on Medicare Contracting To Be Held on Tuesday, April 22, 1986

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee on Health will hold a hearing on issues related to medicare contracting on Tuesday, April 22, 1986. The hearing will begin at 9:30 a.m., and will be held in room B-318, Rayburn House Office Building.

The General Accounting Office (GAO) has recently completed a report, "Medicare Contracting: Existing Authority Can Provide for Effective Program Administration." The report, scheduled to be released during the month of April, discusses the Department of Health and Human Services' use of competitive fixed-price bidding authority and raises several areas of concern regarding medicare program administration.

The Subcommittee wishes to receive testimony concerning medicare contracting issues raised in the GAO report, including the following: The adequacy of medicare contractor funding to support a growing volume of claims and the implementation of program changes; the effect of HCFA's instructions to contractors that claim backlogs be allowed to grow and that claims be processed more slowly on medicare assignment rates, participation, provider cash flow and beneficiary liability; the potential impact of FY 1987 Gramm-Rudman-Hollings cuts in medicare contracting and the Administration's FY 1987 budget request for medicare program administration; the use of Deficit Reduction Act of 1984 competitive bidding authority; and the use of "cost-caps" to constrain payments to medicare contractors, and their impact on erroneous payment rates.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six copies are required and must be submitted by the close of business on Friday, May 9, 1986, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

Chairman **Stark**. The Subcommittee on Health will proceed.

AVAILABLE

Today, we are going to examine the Medicare administrative budget. While the hearing concerns rules and paperwork, it also deals with money and the efficiency of the entire Medicare Program. We will be asking whether the public is getting its money's worth, both from the contractors, and from Medicare generally.

This is an area of continuing concern to this subcommittee. For some time we have had a concern that the program was losing dollars because of its efforts to save dimes. Medicare contractors, the intermediaries, and carriers, who decide whether providers should be paid, and if so, how much, are the first line of defense against getting ripped off. They are the watchdogs. If we starve them, we will run the risk that their performance will suffer, and that we will go unprotected, and this problem is not dissimilar from the Customs and Internal Revenue Service budgets, which are also of concern to the Committee on Ways and Means. Attempts to economize there can actually cost money because the dollars saved by not hiring people are exceeded by the dollars lost in revenues that go uncollected.

So it is or may be with the Medicare Program. If the contractors are paid an insufficient amount to process claims, there will be a natural tendency to simply pay the claims with minimal review, or indeed, dismiss them out of hand, and harm the beneficiaries who then have to get into an appeal process. The contractor budget can look impressively small, but the larger program will suffer.

On the other hand, we do want to minimize the amount spent on administrative functions. We should pay an adequate amount for claims processing, and not more. While we do not want the administration to be penny-wise and pound-foolish, as appears possibly now to be the case, we do not want it to be penny-foolish, either.

Our goal today is to determine how the administrators of the Medicare budget are handling this delicate balancing act.

Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman. I am very pleased that this hearing is being held because I am increasingly hearing concerns raised from providers, as well as beneficiaries, about the issues which are the subject of our hearing today.

I am particularly concerned about statements which have come to my attention, recently, from a number of hospitals and other providers, including, for example, suppliers of durable medical equipment, that the payment is slipping in terms of time. That is to say that the Government has become a late payer in many instances, and that these providers are required to seek sources of financing because the Government is not paying on time.

Recently, I met with a manufacturer of durable medical equipment in my own district, who indicated that in some instances, valid claims—that is not really at issue—have been left unpaid for in excess of 120 days. Since these claims are not assignable, this particular company is having great difficulty financing its own operations because of slow pay from the Government.

As a result, Mr. Chairman, in listening to the testimony today, I am going to be weighing in my mind, whether it would be wise for us to add to an appropriate piece of Medicare legislation, a requirement such as we have put into effect in the tax laws, which might say something like this. That valid claims not paid after properly being presented, and after a 30-day period, would carry interest at the Federal rate. We did that with the IRS, and it proved extremely helpful in getting refunds out on time, and I think that we may have reached the point where a step of that kind might be appropriate with regard to Medicare payments as well, since after all, the Government has accepted responsibility for purchasing these services, and I think has an obligation to pay on time if the service has been rendered.

Thank you, Mr. Chairman.

Chairman **Stark**. Thank you. Our first witness will be Michael Zimmerman, the Associate Director of the Human Resources Division of the General Accounting Office.

And as is generally our case, we are going to, after the first two witnesses, hold our panel members to a 5-minute summary of their testimony, which was graciously provided to the staff and committee ahead of time, and that will allow the members a little more time for questioning.

It is also our intention to go straight through this morning until we finish. The committee has additional hearings this afternoon, and so we would like to move on. If we find we have additional time in the subsequent panels, we will stretch that out. I am happy to see Mr. Zimmerman here. Would you like to introduce your companion for the clerk's record, and proceed in any manner that you care to.

STATEMENT OF MICHAEL ZIMMERMAN, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY THOMAS DOWDAL

Mr. **Zimmerman**. Thank you very much, Mr. Stark. Let me begin by introducing Mr. Dowdal. Mr. Thomas Dowdal is in charge of our work on the Medicare Program.

We are pleased to be here today to discuss a number of issues presented in our report on Medicare contracting which was issued today. This report reflects the results of the GAO review required by the Deficit Reduction Act of 1984.

As requested, our testimony will address the adequacy of the funding available to the contractors who process and pay Medicare claims, the relationship between the funding levels, and the accuracy of program payments and quality of service, and HCFA's use of competitive authority provided by DEFRA.

Let me begin by saying that we view Medicare contracting operations from two perspectives. First, is Medicare receiving fair value for what it pays contractors? That is, are contractor operations efficient and economical?

Second, and equally as important: Are the contractors adequately protecting Medicare against erroneous payments and providing quality services to beneficiaries and providers? That is, are they effective?

We have made many recommendations over the years to improve contractor operations from both perspectives. The recommendations have included controlling administrative costs by terminating high-cost contractors, requiring more uniformity in contractor operations to better safeguard program payments, and improving beneficiary and provider services. Balancing efficiency and economy of contractor operations with effectiveness is not easy for HCFA, and the contractor budget process is an important tool for doing so. As discussed in our current report, we are concerned that in recent years, budgetary controls on the efficiency and economy side of the equation may be degrading the effectiveness side. While we recognize that HCFA needs to control contractor costs, we do not believe it should be done at the expense of contractor effectiveness in making accurate and timely program payments, or providing quality beneficiary services. Overemphasis on reducing the 1.3 percent of Medicare costs paid to contractors could result in reduced contractor effectiveness in controlling the 97.5 percent paid out as benefits.

Since the beginning of Medicare, benefit payments have increased dramatically year after year, while intermediary and carrier costs have increased more moderately. For example, during the period 1980 to 1984, benefit payments nearly doubled, but total contractor administrative costs increased by only a third. On a cost per claim basis, in constant 1970 dollars, from 1970 to 1984, the unit cost of processing part A claims decreased from $6.34 to $2.33, while the unit cost of part B claims decreased from $3.16 to $0.85.

Currently, administrative costs represent only 2.5 percent of total program payments. This compares favorably with the administrative costs incurred by large private insurers, which are about 7 percent of premium revenues.

To their credit, HCFA and the contractors have kept Medicare administrative costs relatively low, even though required to implement many programmatic changes during the past few years.

Turning now to your specific questions, you asked. Is Medicare's contractor funding adequate? Basically, we concluded in our report that the administration's budget request for contractor funding in fiscal years 1985 and 1986 were inadequate, particularly when considered in light of the legislative and Agency-imposed additional work requirements that occurred after the budgets were submitted to the Congress.

Although HHS did not request additional funds, the Congress did appropriate additional amounts for both fiscal years. However, total contractor funding for fiscal year 1985 was still inadequate, and probably resulted in contractors absorbing some Medicare costs as well as an increased claims backlog.

While the amount appropriated by the Congress for contractor funding in fiscal year 1986 was probably adequate, the Gramm-Rudman-Hollings reduction that occurred in March sequestered $42 million, and again left contractor funding very tight.

Our report does not cover the fiscal year 1987 budget. However, the administration's fiscal year 1987 budget request for contractor funding asks for an increase of only about 3 percent over the amount appropriated by Congress in fiscal year 1986. Because of the expected increase in contractor workload, and the likelihood of additional work for contractors resulting from the budget reconciliation/Gramm-Rudman-Hollings process, we believe that the administration's contractor budget request for fiscal year 1987 may be inadequate.

Our primary concerns are that inadequate contractor funding can lead to: First, a degradation of services to beneficiaries, and second, a loosening of safeguards over program payments.

As discussed in our report, the latest HCFA data indicate that both of these undesired outcomes are occurring. The Budget Reconciliation Act which became law a few weeks ago promises relief to the potential budget crunch. It authorizes $105 million in additional contractor funding in each of fiscal years 1986, 1987, and 1988 for safeguard activities.

Assuming these funds are appropriated, our concern about the program safeguard area will be alleviated. However, most of the recent funding cuts have come from the portion of the budget covering claims processing, which is critical to both the identification of claims for review by safeguard activities and the timely and accurate payment of claims. Thus, we believe that the adequacy of funding for claims processing needs to be looked at by the Congress during the appropriations process.

You also asked, Is the use of "cost caps" are appropriate? To stay within the administration's budget request for fiscal year 1985 and 1986, HCFA used formula-based contractor "cost caps." In effect, the formula required all contractors to reduce their costs.

HCFA justified cost-per-claim caps under the authority provided by DEFRA to restrict payments to contractors to the cost of an efficient and economical contractor. However, we believe that HCFA inappropriately used this authority.

The conference report on DEFRA shows that this authority was to be used to control payments to inefficient contractors, that a standard for efficiency was to be used, and that individual contractor circumstances were to be considered in any cost cutting measures. Although HCFA did consider some individual contractor circumstances in developing the cost caps, it did not consider other important ones that result in legitimate differences in contractor costs.

In summary, we believe that the process HCFA used to set the cost caps was based on available funds rather than on a true standard of economy and efficiency, and was used to spread the estimated budget shortfalls among all contractors rather than to reduce the cost of inefficient ones.

We also believe that cost caps have had an adverse effect on contractor performance. The latest HCFA data shows that claims backlogs and average processing times are both increasing. Because of limits on contractor funding, HCFA is permitting contractors to slow down the average time to pay claims and to increase claims backlogs. While the average time to process a part B beneficiary claim was 12.3 days during fiscal year 1984, it increased to 20.3 days in January 1986. Also, average backlogs increased from 7.7 million claims in fiscal year 1984 to 13.7 million claims in January of this year.

The primary benefit of slower claims payment is that the invested Medicare trust fund money can earn more interest. But increased backlogs create risks and costs. Intentionally letting backlogs grow is risky because it leaves no margin for unexpected problems. Also, large backlogs and slower claims payment can increase program administrative costs because they can generate more beneficiary and provider inquiries, as well as more claim resubmissions. This, in turn, can increase contractor workloads, and can further exacerbate backlogs and slow down claims payment.

You also asked that we discuss how increased backlogs and slower claims payment will affect provider participation, assignment rates, beneficiary liability, and provider cash-flow.

Because many part A providers (such as hospitals and home health agencies) receive periodic interim payments based on their past claims history, neither their cash-flow nor their program participation should be affected much.

However, part B providers, mainly physicians, would have their cash-flow affected. We are not able to predict what effect this could have on participation or assignment rates, but it certainly should not increase these rates.

To the extent, if any, that assignment rates decrease, beneficiary liability would increase.

You also asked what the potential effects of a Gramm-Rudman-Hollings cut in fiscal year 1987 will have on Medicare contractor funding. This funding is subject to sequestration just like other nonexempt spending. Any cut in funding would probably affect contractor performance, and the larger the cut, the more adverse the effect. Backlogs and average payment time could increase further, and payment error rates could go up.

Finally, HCFA has not yet used the DEFRA authority to obtain competitive bids for contracts but has told us that it plans to conduct two competitions this year.

As discussed in our report, HCFA has interpreted the DEFRA provision as only providing authority to seek competitive bids for cost contracts. We disagree and believe that HCFA can use the authority to award competitively fixed contracts.

We have concluded that limited authority to competitively award Medicare contracts could be a useful tool in a coordinated HCFA strategy for managing contractors, and we believe that the Congress should consider extending this limited authority.

This concludes my prepared remarks and I will be glad to answer any questions you may have.

[The statement follows:]

STATEMENT OF MICHAEL ZIMMERMAN, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee, we are pleased to be here today to discuss a number of issues presented in our just issued report, "Medicare: Existing Contract Authority Can Provide for Effective Program Administration." This report reflects the results of the GAO review required by the Deficit Reduction Act of 1984 (DEFRA).

As requested, our testimony today will address the adequacy of the funding available to the contractors who process and pay Medicare claims, the relationship between the funding levels and the accuracy of program payments and quality of services, and the Health Care Financing Administration's (HCFA's) use of competitive authority provided by DEFRA.

GAO'S VIEW OF THE CONTRACTOR FUNCTION

We view Medicare contractor operations from two perspectives:

Is Medicare receiving fair value for what it pays the contractors? That is, are contractor operations efficient and economical?

Are the contractors adequately protecting Medicare against erroneous payments and providing quality services to beneficiaries and providers? That is, are they effective?

We have made many recommendations over the years to improve contractor operations from both perspectives. The recommendations have included controlling administrative costs by terminating high-cost contractors, requiring more uniformity in contractor operations to better safeguard program payments, and improving beneficiary and provider services. Balancing efficiency and economy of contractor operations with effectiveness is not easy for HCFA, and the contractor budget process is an important tool for doing so. As discussed in our current report, we are concerned that in recent years budgetary controls on the efficiency and economy side of the equation may be degrading the effectiveness side. While we recognize that HCFA needs to control contractor costs, we do not believe it should do so at the expense of contractor effectiveness in making accurate and timely program payments or providing quality beneficiary services. Overemphasis on reducing the 1.3 percent of Medicare costs paid to contractors could result in reduced contractor effectiveness in controlling the 97.5 percent paid out as benefits.

With these general comments in mind, I will now provide some background information on contractors and then turn to the specific questions you asked us to discuss.

THE ROLE OF MEDICARE CONTRACTORS

HCFA contracts with insurance companies—called intermediaries for part A and carriers for part B—to process Medicare claims. Currently, Medicare has intermediary contracts with six commercial insurance companies, two Blue Cross plans, and the Blue Cross and Blue Shield Association, which in turn subcontracts with 45 local Blue Cross plans. Medicare has carrier contracts with nine commercial insurance companies and 28 Blue Shield plans.

In fiscal year 1985, the government paid intermediaries and carriers about $933 million to process about 330 million claims for health services provided to about 31 million beneficiaries. The claims resulted in payments of over $60 billion from the Medicare Trust Funds.

Since the inception of Medicare, benefit payments have increased dramatically year after year, while intermediary and carrier costs have increased more moderately. For example, during the period 1980 to 1984, benefit payments nearly doubled from $33 billion to $59.9 billion, but total contractor administrative costs increased by only about a third, from $614 million to $822 million. On a cost-per-claim basis, in constant 1970 dollars, from 1970 to 1984 the unit cost of processing part A claims decreased from $6.34 to $2.33, while the unit cost of part B claims decreased from $3.16 to $.85.

Currently, administrative costs represent only 2.5 percent (about 1.3 percent for Medicare contractors) of total program payments. This compares favorably with the administrative costs incurred by large private insurers, which are about 7 percent of premium revenues. To their credit, HCFA and the contractors have kept Medicare administrative costs relatively low even though required to implement many programmatic changes. During the past few years, contractors have had to adjust their operations to implement: the Prospective Payment System for hospitals; the Medicare Secondary Payer Program; new benefits, such as payments to hospices and comprehensive outpatient rehabilitation facilities; a new uniform bill used by providers for Medicare and other payers; a new medical coding system for part B services; toll-free telephone lines for beneficiaries and participating physicians; and expanded program safeguard activities.

IS MEDICARE'S CONTRACTORS FUDING ADEQUATE

Our report extensively discusses the adequacy of contractor funding. Basically, we concluded that the administration's budget requests for contractor funding in fiscal years 1985 and 1986 were inadequate, particularly when considered in light of the legislative and agency-imposed additional work requirements that occurred after the budgets were submitted to the Congress. Although HHS did not rquest additional funds, the Congress did appropriate additional amounts for both fiscal years. However, total contractor funding for fiscal year 1985 was still inadequate and probably resulted in contractors absorbing some Medicare costs as well as an increased claims backlog.

While the amount appropriated by the Congress for contractor funding in fiscal year 1986 (which exceeded the administration's request by $43.5 million) was probably adequate, the Gramm-Rudman-Hollings reduction that occurred in March sequestered $42 million and again left contractor funding very tight.

Our report does not cover the fiscal year 1987 budget. However, the administration's fiscal year 1987 budget request for contractor funding asks for an increase of only about 3 percent over the amount appropriated by the Congress in fiscal year 1986. While the request represents about an 8-percent increase over the lower level of funds actually available for fiscal year 1986 after sequestration, it could still be inadequate. Because of the expected increase in contractor workloads and the likelihood of additional work for the contactos resulting from the budget reconciliation/Gramm-Rudman-Hollings process, we believe the administration's contractor budget request for fiscal year 1987 may be inadequate.

Our primary concerns are that inadequate contractor funding can lead to (1) a degradation of services to beneficiaries and (2) a loosening of safeguards over program payments. As discussed in our report, the latest HCFA data indicate that both of these undesired outcomes are occurring. The Consolidated Omnibus Budget Reconciliation Act, which became law a few weeks ago, promises relief to the potential budget crunch. It authorizes $105 million in additional contractor funding in each of fiscal years 1986, 1987, and 1988 for safeguard activities. Assuming these funds are appropriated, our concern about the program safeguard area would be alleviated. However, most of the recent funding cuts ($90 million in fiscal years 1985 and 1986) have come from the portion of the budget covering the claims processing subfunction, which is crucial to both the identification of claims for review by safeguard activities and the timely and accurate payment of claims. Thus, we believe that the adequacy of funding for claims processing needs to be looked at by the Congress during the appropriations process.

IS THE USE OF "COST CAPS" APPROPRIATE

To stay within the administration's budget request for fiscal years 1985 and 1986, HCFA used formula-based contractor "cost caps." In effect the formula required all contractors to reduce their costs. HCFA justified cost-per-claim caps under the authority provided under DEFRA to restrict payments to contractors to the cost of an efficient and economical contractor. However, we believe that HCFA inappropriately used this authority.

The conference report on DEFRA shows that this authority was to be used to control payments to inefficient contractors, that a standard for efficiency was to be used, and that individual contractor circumstances were to be considered in any cost cutting measures. Although HCFA did consider some individual contractor circumstances in developing the cost caps, it did not consider other important ones that result in legitimate differences in contractor costs. Such factors as the percentages of paperless claims and assigned claims were not considered. And HCFA's formula-based cost caps resulted in reductions for all contractors without applying a standard for efficiency.

In summary, we believe that the process HCFA used to set the cost caps was based on available funds rather than on a true standard of economy and efficiency and was used to spread estimated budget shortfalls among all contractors rather than to reduce the costs of inefficient ones. We also believe the cost caps have had an adverse effect on contractor performance. The latest HCFA data show that claims backlogs and average processing times are both increasing.

WHAT WILL RESULT FROM INCREASED CLAIMS BACKLOGS

Because of limits on contractor funding, HCFA is permitting contractors to slow down the average time to pay claims and to increase claims backlogs. While the average time to process a part B beneficiary claim was 12.3 days during fiscal year 1984, it increased to 20.3 days in January 1986. Also, average backlogs increased from 7.7 million claims in fiscal year 1984 to 13.7 million claims in January 1986. The primary benefit of slower claims payment is that invested Medicare Trust Fund money can earn more interest. But increased backlogs create risks and costs.

Intentionally letting backlogs grow is risky because it leaves no margin for unexpected problems. In numerous instances in our past Medicare work, we have noted large backlogs caused by problems in implementing new data processing systems or HCFA initiatives. Program and system changes are common, and problems can be expected. However, the additional backlogs caused by these problems could be particularly damaging to beneficiaries and providers when backlogs are already high. Also, large backlogs and slower claims payment can increase program administrative costs because they can generate more beneficiary and provider inquiries as well as more claim resubmissions. This, in turn, increases contractor workloads and can further exacerbate backlogs and slow down claims payment.

You asked that we discuss how increased backlogs and slower claims payment would affect provider participation, assignment rates, beneficiary liability, and provider cash flow. Because many part A providers (such as hospitals and home health agencies) receive periodic interim payments based on their past claims history, neither their cash flow nor their program participation should be affected much. However, part B providers, mainly physicians, would have their cash flow affected. We are not able to predict what effect this could have on participation or assignment rates, but it certainly should not increase these rates. To the extent, if any, that assignment rates decrease, beneficiary liability would increase.

WHAT ARE THE POTENTIAL EFFECTS OF A GRAMM-RUDMAN-HOLLINGS CUT IN FISCAL YEAR 1987

We do not know if a Gramm-Rudman-Hollings sequestration will occur in fiscal year 1987 or, if one does, the extent of such a sequestration for Medicare contractor funding. This funding is subject to a sequestration just like other nonexempt spending. Of course, any cut in funding would probably affect contractor performance, and the larger the cut, the more adverse the effect. Backlogs and average payment time could increase further, and payment error rates could go up.

USE OF DEFRA COMPETITIVE BIDDING AUTHORITY

HCFA has not yet used the DEFRA authority to obtain competitive bids for contracts but has told us that it plans to conduct two competitions this year. As discussed in our report, HCFA has interpreted the DEFRA provision as only providing authority to seek competitive bids for cost contracts. We disagree and believe that HCFA can use the authority to award competitive fixed-price contracts.

We have concluded that limited authority to competitively award Medicare contracts could be a useful tool in a coordinated HCFA strategy for managing contractors, and we believe that the Congress should consider extending this limited authority.

This concludes my prepared remarks. I will be pleased to address any questions.

Chairman STARK. Thank you very much. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman. I have heard complaints, recently, that the periodic interim payments, indeed, would not be continued on the basis that they are today, but that unless the claims were made in a certain required manner—I think on tape—and unless the accuracy rate was in excess of something like 95 percent—and I may have those numbers wrong—that continued available of PIP would be ended.

Are you familiar with the situation with regard to these new proposals for the periodic interim payment system?

Mr. ZIMMERMAN. I am not, Mr. Gradison, but maybe Mr. Dowdal has some information on it.

Mr. DOWDAL. HCFA has proposed changes in the procedures for periodic interim payments, which would require greater use of automated claims filing, but I do not recall the exact extent of the rates that were required in that proposal. But it would tighten up on it. In other words, HCFA is saying if you want to get the interim payments, you have to provide us the claims on a machine-readable basis, and they have to be done within a certain timeframe, a certain number, and they have to be accurate. Otherwise, Medicare would not continue the periodic interim payment.

It is a cost cutting kind of measure because it is much easier, or, not easier, but cheaper to process automated claims.

Mr. GRADISON. Thank you. I raise that at this point, Mr. Chairman, only because I think it is important that we not assume that that program may not be changed, and indeed, were it to be changed, it could substantially affect the cash situation of many providers who have counted on continuation of PIP.

Mr. **Dowdal**. We were just pointing out in our statement, that for providers who are on PIP, a slow down in claims payment time would not really have a serious impact on them.

Mr. **Gradison**. I understand that. Thank you.

Chairman **Stark**. Mr. Zimmerman, for me, if you can, in the time of a minute or so, give me kind of a trace-through of what happens to a claim. Somebody goes in to have a broken arm set. Where do the pieces of paper go?

Can you run me through the system, or, is it so different in every case that——

Mr. **Zimmerman**. Well, there are some differences. Basically, if a person visits a physician and a physician's a participating physician, the physician will send the claim to the carrier, which are usually located on a geographic basis, and the——

Chairman **Stark**. By carrier, you mean the intermediary?

Mr. **Zimmerman**. Well, intermediaries generally process claims for hospitals—that is under part A—whereas the carriers perform a similar function for the physician component. They usually process the claims separately.

Chairman **Stark**. You are talking about carriers, that would be a——

Mr. **Zimmerman**. Blue Shield plans are often Medicare carriers. Or another insurance company. The claim is received by the——

Chairman **Stark**. OK. Let's skip that. That would be a MediGap policy, in a sense.

Mr. **Zimmerman**. Not necessarily, if it is——

Chairman **Stark**. Or part B?

Mr. **Zimmerman**. Part B handles the physician part of the program.

Chairman **Stark**. OK. Let's skip over to part A.

Mr. **Zimmerman**. Part A would be a hospital claim. Actually, that has changed, now, as a result of PPS, or maybe Mr. Dowdal would be more up to date on the process they are currently using.

Mr. **Dowdal**. Well, basically, the hospital will fill out a claim form, either on an electronic medium, or paper claim, and will put on it the diagnosis that the patient was treated for. That claim then gets entered into a computer. It generates which DRG that particular claim falls into, and processes through the claim. The payment amount is determined based on the DRG. There are some add-on amounts for the items that continue to be paid on a cost basis. Also, the professional review organization may get involved in reviewing that particular claim, if it falls within——

Chairman **Stark**. Do they do that on a random, on a sampling basis?

Mr. **Dowdal**. Some of them are reviewed on a random basis; some of them are required because of the kind of procedure; some of them are required because the hospital has a bad record. There are a lot of different ways the PRO may get involved.

Chairman **Stark**. And they go through that before it gets sent through for payment?

Mr. **Dowdal**. Not always, but sometimes the PRO does, sometimes it is after the fact; sometimes it is before.

Chairman **Stark**. Is there any reason to have it before? Are they worried that the hospitals will go south with the money and they will not collect, or——

Mr. **Dowdal**. Well, you can get the money back by offset on another claim, but basically, for certain kinds of procedures, where there has been a history of problems with them, the PRO reviews those beforehand. Otherwise, the random ones they do after the fact.

Chairman **Stark**. OK. Then they send this on to the processing center?

Mr. **Dowdal**. Right. And after the claim gets processed through the computer, and the amount is determined, the intermediary writes a check. Normally, a couple of times a month—depending, again, on whether it is a periodic interim payment provider. PIP provides a check every month that covers what they expect to get during that month. The ones that are not on PIP, a couple of times a month, the intermediary will send them a check for the processed claims up through that point.

Then after the fact, you can get into more reviews, depending on what the claims processing shows.

Chairman **Stark**. You have visited different sites. You know them. You have observed different procedures. Do they use fairly similar programs, or do they process in different manners throughout the country?

Mr. **Dowdal**. Well, there are differences but the basic process is pretty much the same. There are different edits and screens, but the basic processing is the same.

Chairman **Stark**. You did find, however, looking through this, that there are substantial differences in the contractor performance?

Mr. **Dowdal**. Right.

Chairman **Stark**. Would you ascribe that to their systems, or to their personnel? How would you weight that?

Mr. **Dowdal**. Well, it is most likely a combination of a number of things. A lot of the variation in contractor costs is due to differences in the circumstances of the contractors, the kind of claims they process, and all of that. And once you remove that part, then you get down to the difference in efficiencies.

Chairman **Stark**. OK. But you show costs in 1984 ranging from about $3.94 up to $10.19. Give me an example of a $3.94 claim as opposed to a $10.19 claim.

Mr. **Dowdal**. Those are average costs for all of the kinds of claims that come through. When you are talking about a difference that large, you are getting into efficiency area, and that is what we are saying in our report is that the ones that HCFA needs to concentrate on are the high-cost ones where there is not a justification for the difference between their cost and the normal cost.

Chairman **Stark**. Well, what makes a high-cost claim on a DRG?

Mr. **Dowdal**. If they have too many people, or if they have an inefficient processing system, too much manual stuff instead of——

Chairman **Stark**. OK. But what I am saying, at the same contractor there should not—I mean a claim is a claim is a claim. Is it harder to process——

Mr. Dowdal. Oh, yes. There are differences among types of claims. It is harder to process a home health claim for an intermediary. It is harder to process, involves more to process a home health agency claim than it does a hospital claim.

Chairman Stark. OK. But a hospital claim, ought to be relatively routine.

Mr. Dowdal. Yes. Basically a hospital claim is a hospital claim, unless there is a problem with it.

Chairman Stark. What would be wrong, in either of your opinions—we have got these claims that range from $3.94 to $10.19. We have had some pretty good luck with DRG's, and we are going to a national rate with DRG's. Why not go to a national rate in a claims process, just tack it onto the DRG? What do you see wrong with that?

Mr. Dowdal. You mean pay the hospital for it?

Chairman Stark. No, not pay the hospital; pay the contractor.

Mr. Dowdal. You mean prospectively set an amount for——

Chairman Stark. For each type of claim. You get $2.75 for a home health claim; you get $3.84 for a hospital claim. If you can make it, fine; if you go broke, we will find another contractor.

Mr. Dowdal. Well, basically there probably is not a whole lot of problem with that as long as there is adequate adjustments made for the local differences in the——

Chairman Stark. Wage rates, and that sort of thing. OK.

Mr. Dowdal. Right. Well, there are a number of——

Chairman Stark. Now tell me what is the reason, or the necessity for geographic location? Is there any reason you have got to be close to the hospital, could you do it over the telephone with electronic transfer from——

Mr. Dowdal. The main thing where location makes a difference, is for auditing—auditing and utilization review functions.

Chairman Stark. Auditing whom?

Mr. Dowdal. The regular claims processing——

Chairman Stark. Auditing whom?

Mr. Dowdal. The hospital. Their costs for the cost items, and the medical review kind of functions for nonhospitals.

Chairman Stark. OK. But not necessarily for processing the claims?

Mr. Dowdal. No, that—you know—if you have——

Chairman Stark. It is like check processing?

Mr. Dowdal. Right.

Chairman Stark. OK. We do not use a uniform accounting, or claims processing format?

Mr. Dowdal. We have a uniform bill.

Chairman Stark. Yes, but we do not have a uniform computer program, do we?

Mr. Dowdal. No; no we don't have uniform computer programs.

Chairman Stark. Would that make auditing easier? Any reason that we should not develop a sort of a national computer processing program?

Mr. Dowdal. Not if you assume that you would make a good program.

Chairman Stark. Yes. Well, we would take the best one, it would seem to me.

Mr. DOWDAL. Yes.

Mr. ZIMMERMAN. Well, also, processing medicare claims is a function that carriers and intermediaries perform in conjunction with their other duties, and to the extent that the program is compatible with what they do, and does not create additional problems, so they are actually operating——

Chairman STARK. I am not concerned about the contractor's problems. I am concerned about ours. I mean, would it not make HCFA's job easier, when they are trying to add costs, and audit nationally, and they are working on 6 or 8 or 10 different programs and chart of accounts, it seems to me that the contractors ought to perform at our convenience, not vice versa.

Mr. ZIMMERMAN. I think to a large degree HCFA has not, in the past, prescribed the system requirements that the contractors must follow. You are raising an interesting question.

Chairman STARK. OK. Well, I would just go through some of these averages and say, "Look. I want to find the contractor that is doing this for $3.94 and give him all our business." Why mess around with the contractor that is doing it for $10.19. How much does contracting cost, total?

Mr. ZIMMERMAN. Close to a billion dollars a year.

Chairman STARK. I have just saved us $400 or $500 million. You know, we could all have a pay raise for civil service employees under that scenario.

Mr. ZIMMERMAN. I would not argue with that.

Chairman STARK. It would not be bad, would it?

Mr. DOWDAL. Basically, we have said the same thing—get rid of inefficient contractors—a number of times.

Chairman STARK. What is the correlation between error rates and costs? They now tell me that the contractor doing it for $3.94 has a lower error rate than the contractor doing it for $10.19. Do you find any correlation between costs and error rate?

Mr. DOWDAL. Sometimes you do; sometimes the low-cost ones also have low error rates: but it is not universal.

Chairman STARK. Do you have any figures in terms of who wins the marathon for lowest cost and lowest error rate? Can you identify that contractor for me?

Mr. ZIMMERMAN. I think HCFA can.

Mr. DOWDAL. We could, but I have not got those numbers with me, but we can get those numbers.

Chairman STARK. Would you get them for me.

Mr. DOWDAL. Sure.

Chairman STARK. Just go through and give me some of the lowest cost, with the lowest error rate, and let's compare. And give me some of the highest cost with the highesr error rates. I am not sure there would be a correlation, but it would be kind of interesting.

Mr. ZIMMERMAN. We will be glad to.

[The information follows:]

COMPARISON OF PART B CARRIER COST PER CLAIM AND ERROR RATES

Table 1 lists the carriers with the lowest and highest cost per claim processed in fiscal year 1984 along with their error rates and error rate rankings. A total of 47 contracts were ranked by error rate (rankings exclude 2 fixed-price contractors and 4 contracts where data were not available). The table shows that both the lowest and highest cost per claim contractors generally ranked in the middle range of all contractors on an error rate basis.

Table 1: Error Rate Rankings of the Part B Carriers With the Lowest and Highest Cost Per Claim in Fiscal Year 1984

Contractor/State	Cost/claim	Cost/claim rank	Error rate	Error rate rank
10 lowest cost per claim carriers				
Prudential/NC	$1.88	1	1.2	10
Blue Shield/KY	1.97	2	1.5	19
Blue Shield/PA	2.01	3	1.5	19
Blue Shield/RI	2.06	4	2.0	34
Blue Shield/WI	2.08	5	1.6	22
Aetna/OK	2.09	6	1.6	22
Aetna/AZ	2.09	6	*	*
Blue Shield/ND	2.11	8	1.9	32
Blue Shield/AL	2.12	9	2.7	41
Prudential/NJ	2.13	10	1.3	12
10 highest cost per claim carriers				
Blue Shield/CA	2.63	39	1.4	15
Equitable/WY	2.65	40	1.5	19
Blue Shield/UT	2.66	41	1.8	30
Blue Shield/MD	2.67	42	1.7	27
Equitable/ID	2.70	43	1.9	32
Blue Shield/IN	2.71	44	1.8	30
Blue Shield/MT	2.88	45	*	*
GHI/part of New York City	2.88	45	1.0	9
Pan American/LA	3.04	47	4.0	45
SSS/Puerto Rico	4.83	48	*	*

*Data not available

Table 2 lists the carriers with the lowest and highest payment error rates in fiscal year 1984 along with the cost per claim and cost per claim rankings. Both the lowest and highest error rate carriers generally fall in the middle range of all carriers on a cost per claim basis.

Table 2: Cost Per Claim Rankings of the Part B Carriers With the Lowest and Highest Error Rates

Contractor/State	Error rate	Error rate rank	Cost/claim	Cost/claim rank
11 lowest error rate carriers				
Blue Shield/AK	0.4	1	$2.32	24
Travelers/MN	0.4	1	2.36	28
Blue Shield/NH-VT	0.4	1	2.16	16
Travelers/VA	0.6	4	2.15	14
Aetna/HI	0.7	5	2.21	18
Connecticut General/CT	0.8	6	2.42	30
Travelers/MS	0.9	7	2.34	25
Blue Shield/MN	0.9	7	2.55	36
GHI/part of New York City	1.0	9	2.88	45
Nationwide/OH-WV	1.2	10	2.35	26
Prudential/NC	1.2	10	1.88	1
10 highest error rate carriers				
Blue Shield/KS	2.1	35	$2.62	38
Occidental/Southern CA	2.2	37	2.14	11
Blue Shield/TX	2.4	38	2.30	22
Blue Shield/MA	2.5	39	2.31	23
Blue Shield/SC	2.5	39	2.42	30
Blue Shield/AL	2.7	41	2.12	9
General American/MO	2.7	41	2.45	33
Blue Shield/IA	2.7	41	2.37	29
Blue Shield/FL	3.2	44	2.16	16
Pan American/LA	4.0	45	3.04	47

COMPARISON OF PART A INTERMEDIARY COST PER CLAIM AND CONTRACTOR PERFORMANCE EVALUATION RATINGS

Table 3 lists the intermediaries with the lowest and highest cost per claim processed in fiscal year 1984 along with their Contractor Performance Evaluation Program (CPEP) ratings and rankings. CPEP measures intermediary performance against a uniform set of standards related to cost and effectiveness of operations. The maximum CPEP rating is 100. A total of 66 intermediaries were ranked. Generally, the intermediaries with the lowest cost per claim also were among those with CPEP rankings in the top third of all contractors and the intermediaries with the highest costs had CPEP rankings in the bottom third. This is as expected because cost is an important part of the CPEP rating.

Table 3: CPEP Rankings of the Part A Contractors With the Lowest and Highest Cost Per Claim in Fiscal Year 1984

Contractor/State	Cost/claim	Cost/claim rank	CPEP rating	CPEP rank
10 intermediaries with lowest cost per claim				
Capital Blue Cross/part of PA	$3.94	1	95	10
Philadelphia Blue Cross/part of PA	3.95	2	97	1
Northeast PA Blue Cross/part of PA	4.15	3	96	4
DC Blue Cross/DC metropolitan area	4.19	4	94	22
Pittsburgh Blue Cross/part of PA	4.50	5	95	10
Atlanta Blue Cross/part of GA	4.75	6	92	42
Richmond Blue Cross/part of VA	4.75	7	95	10
NC Blue Cross/NC	5.02	8	95	10
MA Blue Cross/MA	5.06	9	92	42
NJ Blue Cross/NJ	5.08	10	94	22
10 intermediaries with the highest cost per claim				
Central OH Blue Cross/part of OH	$ 8.57	57	80	65
MT Blue Cross/MT	8.84	58	91	49
Sioux City Blue Cross/part of IA and SD	9.19	59	95	10
HI Blue Cross/HI	9.23	60	91	49
ND Blue Cross/ND	9.29	61	95	10
Travelers/some providers in MI	9.47	62	94	22
NB Blue Cross/NB	9.54	63	86	63
ID Blue Cross/ID	9.58	64	90	55
WY Blue Cross/WY	10.19	65	90	55
COOP/Puerto Rico	11.32	66	86	63

Table 4 lists the intermediaries with the highest and lowest CPEP rankings along with their cost per claim and cost per claim ranking. Again, intermediaries with high CPEP rankings tend to have low cost per claim. Intermediaries with low CPEP rankings have costs per claim covering the entire range of contractors.

Table 4: Cost Per Claim Rankings of the Part A Contractors With the Lowest and Highest CPEP Ratings

Contractor/State	CPEP rating	CPEP rank	Cost/claim	Cost/claim rank
21 intermediaries with the highest CPEP ratings				
Southwest VA Blue Cross/part of VA	97	1	$ 5.78	24
Philadelphia Blue Cross/part of PA	97	1	3.95	2
SC Blue Cross/SC	97	1	5.61	21
Travelers/NY	96	4	7.44	48
Northeast PA Blue Cross/part of PA	96	4	4.15	3
DE Blue Cross/DE	96	4	6.00	30
AL Blue Cross/AL	96	4	6.23	33
CA Blue Cross/CA	96	4	5.95	27
TN Blue Cross/TN	96	4	6.78	37
MS Blue Cross/MS	95	10	5.24	15
Columbus Blue Cross/part of GA	95	10	5.49	20
Sioux City Blue Cross/IA part of IA and SD	95	10	9.19	59
NC Blue Cross/NC	95	10	5.02	8
ND Blue Cross/ND	95	10	9.29	61
Richmond Blue Cross/part of VA	95	10	4.75	6
Aetna/some providers in FL	95	10	5.96	28
Aetna/some providers in CA	95	10	7.67	50
FL Blue Cross/FL	95	10	5.94	25
Pittsburgh Blue Cross/part of PA	95	10	4.50	5
Capital Blue Cross/part of PA				
IL Blue Cross/IL	95	10	5.19	14
10 intermediaries with the lowest CPEP ratings				
WY Blue Cross/WY	90	55	$10.19	65
Aetna/some providers in IL	90	55	8.06	53
KS Blue Cross/KS	90	55	6.89	40
TX Blue Cross/TX	89	60	6.79	39
Northwest OH Blue Cross/part of OH	88	61	8.01	52
Mutual of Omaha/overall	88	61	8.08	54
NB Blue Cross/NB	86	63	9.54	63
COOP/Puerto Rico	86	63	11.32	66
IN Blue Cross/IN	80	65	7.25	46
Central OH Blue Cross/part of OH	80	65	8.57	57

Chairman **Stark**. Let me ask you this. Let's assume that there is some contractor out there doing all the work in his kitchen, and his kids do the work free, and he is using illegal aliens for processing, and so you have got a—you know—the outlier in this statistical summary.

But if all the carriers and intermediaries were in the lower 20 percentile of cost, and the upper 20 percentile of efficiency, how many hundreds of millions of dollars do you suppose we would save in a year? Just take a wingshot at that.

Mr. **Dowdal**. Well, if they all were at the lowest part of the cost and the highest part of the efficiency, you would probably cut off—you know—maybe 15 to 20 percent, or something like that of your overall cost.

But really, when you look at those numbers, you have to be a little careful, because there are valid and legitimate differences among contractor costs.

Chairman **Stark**. OK.

Mr. **Dowdal**. You cannot assume that everybody could do it for the lowest amount.

Chairman **Stark**. I am not assuming that. I am just trying to get down to the lower end of the scale. What do you think we could save? Mike, what do you think?

Mr. **Zimmerman**. I think $100 million would be likely. It is kind of interesting, your line of discussion.

Traditionally, our office has taken the position that HCFA needs to spend its time and attention on the high cost contractors, and not trying to penalize all the contractors, but focus on those, particularly those in the bottom 20 percent that are the poor performers, rather than trying to hang everybody.

Chairman **Stark**. Could I ask you this: Is there anything magic about processing part A claims? I mean, is it not generally a mindless sort of paperwork? But no more difficult than processing checks in a bank, is it? Or credit cards?

Mr. **Zimmerman**. Well, there are a couple of components to the process that—the actual processing of the claim, absent the edits and the checks, and the reviews—utilization reviews and things of that nature—it is pretty much a process-oriented thing.

We are talking about hundreds of millions of claims, so I cannot sit here and tell you that is a unique experience, every time it happens. It is pretty much straightforward.

But there are circumstances, if it is a problem claim, and that is the exception; that requires some effort on the part of people. But it is a mass-production-process type thing.

The components of cost that we are talking about here include a number of things, you know, such as beneficiary services, assistance to the provider community to make sure that they are getting their claims in on time, and they understand how to fill out the claims. So there is a lot of components to the contractor funding that, granted, the biggest one is the actual processing of the claim, but there are other components in there that make it somewhat of a complex process.

Chairman **Stark**. But those sound to me like you are getting at the peer review things, and the quality checks, which are outside the—just the bookkeeping function.

Mr. **Zimmerman**. No; no.

Chairman **Stark**. No? All right.

Mr. **Zimmerman**. There is a significant amount of utilization review that is conducted electronically in most instances, and manually, in other instances, when a claim is submitted.

The big question is, Is this a duplicate payment? Have we already paid this claim? So some attempt has to be made to check for that, and then there is a question of whether the claim is for covered services, or not.

A lot of those types of checks are done in an automated fashion, but——

Chairman **Stark**. I would think so.

Mr. **Dowdal**. On the part B side, a lot of it is. On the part A side, the actual computing, running it through and figuring out we are going to pay them so much for this claim, is a relatively small part of the overall costs of the intermediary.

Chairman **Stark**. Let me ask you something. For a Medicare beneficiary, do we use a unique identifier?

Mr. **Dowdal**. Yes.

Chairman **Stark**. Social Security number.

Mr. **Dowdal**. Right. Well, Social Security number with a letter added on to it.

Chairman **Stark**. Right. So there is no way that somebody can game the system there. I mean——

Mr. **Zimmerman**. Of the provider bills, there is always a possibility someone can manipulate the system, being a provider. Usually it would be a provider that would be apt to do it rather than a beneficiary.

Chairman **Stark**. Yes. So they would have to find another number to plug into the system. But if they did that very often, I would think the system would hiccup and identify that.

Mr. **Zimmerman**. I do not know exactly what percentage of claims are rejected because they are duplicate payments or erroneous claims. Maybe Mr. Dowdal has some kind of information on that.

Chairman **Stark**. But you do not see anything vicious about suggesting that we just start to break these things down into their component parts and offer a fee for them, like we do DRG's. Do you see anything, particularly on the bookkeeping, in the more routine processing? Is there any reason that we could not just take a number and say, "That's what we'll pay"?

Mr. **Dowdal**. For the straight claims processing part, that is relatively easy to do, but that is not the only part, as Mike pointed out.

Chairman **Stark**. No. I understand that.

Mr. **Dowdal**. And, you know, we kind of feel that it is important to keep the parts together. It may not be so easy to break those parts apart, and say somebody do this and somebody else do this part. There can be benefits from having it all together.

Chairman **Stark**. You are stirring your hand around there. Now explain that to me. That is what I am trying to get at.

Mr. **Dowdal**. If you have somebody who you are paying to process the claim, and that is their only function, then that is what they are emphasizing, and they are going to be measured based on certain things related to just claims processing.

So they are going to shoot for whatever they are measured against. And somebody else doing medical review, they are going to be focusing on that.

Chairman Stark. OK. Now I am talking about the medical review that is not cranked out by the computer. It is not catching——

Mr. Dowdal. Right. But what is also important in looking at the medical review is the computer because it is what does a lot of the identification of the kind of claims you want to look at.

Chairman Stark. I understand that. But that ought to be done on every claim, right? The computer, it seems to me, is going through the process of analyzing the claim, and it may spit out an error report; it may spit out an exception report. But until it cranks out the reports, is there any reason until somebody has to look at the report and decide whether the computer has generated some data that is worth reviewing up to that point, we could not just put a piecework price on it?

Mr. Dowdal. Well, as I was trying to say, Mr. Stark, it is very important that the person who is generating these reports, his incentives under a contract just for claims processing might be to put out big piles of these reports to give to somebody else, but the reports will not be worth anything. That is the kind of problem you can get into when you separate the functions.

Now separate contractors for different functions has never been really tested, so we do not know exactly how it would end up working.

Mr. Zimmerman. I think what Mr. Dowdal is saying is that if you separate out the components of the process, and you reimburse or reward people for doing their component, we may end up with—for example, the claims processing component may just march those claims through as quickly and as fast as possible, simply because that is what their incentive is, to get them all done.

Now, the other person who has to review the claims, and come up presumably with overpayments, or erroneous payments, may reject an awful lot of claims just to keep their statistics up and show that they are doing a good job.

Chairman Stark. You mean the whole world is against us out there?

Mr. Zimmerman. Well, I would not want to say that. I think probably an equally good argument as to why it is a good idea to keep the functions intact is that there is an awful lot of overlapping functions that are performed.

The person who is processing the claim is also reviewing the claim, is also setting the claims history to come up with a reimbursement rate for subsequent years.

So there is a lot of interrelationship in the process, and I guess maybe you could get component prices that are going to be cheaper, but collectively, I cannot see the economy. I think when you add up all the pieces, it will probably be equal to or greater than the price of what you are paying now for the efficient carriers, or intermediaries.

Chairman Stark. Well, as I say, it seems to me you are reviewing them here, you are giving me prices on unit costs for part A, and I am just suggesting that if we use those to bid, that we have got a big range there.

Mr. **Dowdal**. In effect, Mr. Chairman, what we think under the DEFRA authority, on the efficiency, economy side, would be more in line with what was envisioned when it was written is was something along the lines of a section 223 kind of limit that you have for providers, where you set a standard of efficiency and you will not pay anybody more than that standard of efficiency. That is what we saw as the DEFRA authority.

Chairman **Stark**. $3.94. How does that sound like a standard?

Mr. **Dowdal**. Well, if that is the lowest one, I would not think it would be a proper standard, but I am sure there is a way you can come up with a fair standard and then you say we are not going to pay more than that.

Chairman **Stark**. OK. Mike, in your testimony, you are saying that we are loosening up the safeguards in the program. Can you elaborate on that a little bit, and can you quantify how many millions you think we are losing through these loosening up the safeguards, which I assume is to save money.

Mr. **Zimmerman**. We do not have an exact amount that I can point to. A number of the contractors have told us that they are no longer able to do even the minimum safeguards that have been built into the program. As we indicated in our statement, about 30 percent of the processing costs of a claim are actually costs that are involved in protecting the program through safeguards.

Many of the contractors have failed to CPEP standards of 1980.

Chairman **Stark**. Which standards?

Mr. **Zimmerman**. These are the standards that deal with the safeguard requirements of the program. CPEP is the acronym.

Chairman **Stark**. And we let the contractors make their own decisions as to how they are going to process and meet those standards, or does each contractor do it in their own wondrous and mysterious way?

Mr. **Zimmerman**. Well, the standards are set and they have to meet or exceed them. If they fail, then points are assessed against them, and theoretically, they could be thrown out of the program.

That has not happened very frequently in the past. But as I said, many of the contractors have failed—I do not have the exact number—the safeguard standards, which suggest that they are not protecting the program to the extent that was expected of them. This was in this past year.

And we feel that to some degree, that is a result of the fact that they just have not been able to put the attention toward the safeguard requirements that was expected of them.

Mr. **Dowdal**. One example is, recently, HCFA deferred auditing of a number of non-PPS providers. Auditing, historically, has been a very cost-effective function. I believe the number was somewhere around $10 million and the return has normally been 7 to 10, to 1. So, in effect, if you cut auditing $10 million you increase program benefit payments by a hundred million, by between $50 and $100 million. So that is the kind of impact.

Chairman **Stark**. Let me ask you this: how many contractors would make up 60 or 70 percent of the total claims? Do you have some major population centers where 10 contractors take 70 percent of the work? Or where are we in that?

Mr. DOWDAL. You take the large States like California, New York, Florida, Pennsylvania——

Chairman STARK. You have two contractors in California, or one?

Mr. DOWDAL. Yes.

Chairman STARK. Two.

Mr. DOWDAL. Two part B, and——

Chairman STARK. What about part A?

Mr. DOWDAL. Part A, there is basically one.

Chairman STARK. One in California.

Mr. DOWDAL. Right. There are other——

Chairman STARK. OK. That is 20 percent of the business there.

Mr. DOWDAL. Yes. If you add on New York and Florida, and Pennsylvania, and Ohio, and Illinois, we are up over, in the area of 50 percent of all the claims.

Chairman STARK. OK. And that 50 percent of all the claims—and that is how many contractors, roughly?

Mr. DOWDAL. That would probably be about 12 to 15 contractors.

Chairman STARK. OK. Now, is there a major difference—in those 12 to 15, forget about the little scattered ones—are there major procedural differences, or are there major cost differences?

Mr. DOWDAL. Offhand, I do not know. I do not have the numbers.

Chairman STARK. You do not know, either?

Mr. ZIMMERMAN. No. I do not have that.

Chairman STARK. That would seem to me to be interesting. I can see that there would be a major difference between somebody in North Dakota as opposed to New York City. I mean, the volume, and everything else could be tremendously different, but as between northern and southern California—for example—I do not know why there should be any difference. I guess what I am getting at is, do you know whether there are just different procedures used, widely different computer programs, types of processing?

Mr. DOWDAL. I would think the major difference between any—that would account for differences among contractors, once you take out the variables that are legitimate, like claims mix and stuff like that, would be efficiencies. Some are more efficient than others. There is no question about that.

And as we have said a number of times in the past, we think there are too many contractors. There still is. They have cut down on the number of contractors by consolidations and that, but there is probably still too many.

Chairman STARK. The next question goes this way: Assuming that a claim is a claim is a claim from a hospital, under part A. Wouldn't it be easier for HCFA, in terms of overall auditing, and gathering data, in the sense of our being able to understand the program, to go to a prescribed chart of accounts processing format, so that when all this information comes back eventually to HHS, it is uniform.

And it would seem to me it can be transmitted electronically. I would assume now, that HCFA has to translate the data that is collected in different ways from different contractors, and that would make the auditing procedure far more complex.

Mr. **Dowdal**. In the last few years HCFA has moved very much toward that direction. They now have a uniform bill for hospitals and one for physician claims, and I believe everyone is now using those, all of the contractors, and they now have a common coding system, so they can now bring all that stuff together. Of course a few years ago, they could not easily consolidate data and it made it a lot harder to do any kind of research or auditing, or anything like that.

Chairman **Stark**. So, what we might lose in efficiency, for some small processor who may have a "magic" system, we would pick up in perhaps accuracy and improved data.

Mr. **Dowdal**. Right.

Mr. **Zimmerman**. Of course setting up a system is one thing. Keeping it up to date, and modern, is something else, and if HCFA would do that, they would have to take on a tremendous responsibility to make sure the system that they do set up is state of the art, and stays state of the art.

Chairman **Stark**. Well, you know, the rewards look great. Now, these 10 or 12, or 15 providers with 50 percent of the business, if they are up in the $10 range, to get them down into the $4 range, the rewards are great.

Mr. **Zimmerman**. And Mr. Chairman, that has basically been our position over time, and we think that the agency has sufficient authority to do just exactly what you are saying, is to pursue those contractors that are not doing a good job, and get them to either do a good job, or leave the program.

Chairman **Stark**. In this draft GAO report that I am fussing with here, could you evaluate it for me, and when you get to the 50-percent mark take those contractors, and crunch a few numbers there. Whatever you have got, see if you can feed that back through. I think that would be tremendously informative. They may be very uniform, and if they are on the low end, we are in great shape. But it would be interesting to know that, and I gather right now, you do not.

Mr. **Zimmerman**. We do not have it in front of us. That information is published, I believe, by the agency. It does break out carriers and intermediaries by their ranking.

I do not know if it actually lists their workload adjacent to their costs; maybe it does; maybe it doesn't. But we could locate that.

[The information follows:]

COST PER CLAIM PROCESSED OF CONTRACTORS REPRESENTING ABOUT HALF OF TOTAL WORKLOAD

Table 1 lists the Medicare contractors with the largest workloads in 1984. The 14 part A contractors listed processed about 50 percent of the total part A workload, while the 10 part B contractors listed processed about 56 percent of the total part B workload.

There is no clear pattern in the costs per claim of these contractors relative to the rest of the contractors. The 14 part A contractors had cost per claim rankings generally in the mid-range of all the part A contractors. Eight of the 14 contractors had costs per claim that were lower than the national average for all part A contractors, and 6 had costs that were higher. Likewise, the 10 part B contractors had cost per claim rankings that fell in the mid-range of all part B contractors. Six of the 10 had costs per claim lower than the national average for all part B contractors, 3 had higher costs per claim, and 1 was the same as the national average.

Table 1: Fiscal Year 1984 Costs Per Claim of the Contractors With the Largest Workloads

Contractor/State	Workload	Workload rank	Cost claim	Cost claim rank	Difference from national average cost/claim ($6.10)
14 intermediaries with the largest workloads					
CA Blue Cross/CA	3,270,626	1	$5.95	27	$ (.15)
MI Blue Cross/MI	2,148,609	2	5.94	25	(.16)
IL Blue Cross/IL	2,112,856	3	5.19	14	(.91)
MA Blue Cross/MA	1,861,505	4	5.06	9	(1.04)
FL Blue Cross/FL	1,819,762	5	5.94	25	(.16)
TX Blue Cross/TX	1,688,974	6	6.79	39	.69
Pittsburgh Blue Cross/ part of PA	1,432,531	7	4.50	5	(1.60)
NC Blue Cross/NC	1,045,376	8	5.02	8	(1.08)
IN Blue Cross/IN	996,245	9	7.25	46	1.15
Mutual/overall	973,778	10	8.08	54	1.98
WI Blue Cross/WI	964,517	11	6.46	36	.36
TN Blue Cross/TN	937,540	12	6.78	37	.68
Philadelphia Blue Cross/part of PA	929,757	13	3.95	2	(2.15)
Cincinnati Blue Cross/ part of OH	929,022	14	6.09	32	(.01)
10 carriers with the largest workloads					
PA Blue Shield/PA	16,690,943	1	$2.01	3	$(.30)
FL Blue Shield/FL	15,929,013	2	2.16	16	(.15)
Blue Shield/greater New York	14,175,297	3	2.61	37	.30
Occidental/CA	12,772,951	4	2.14	11	(.17)
CA Blue Shield/CA	11,569,665	5	2.63	39	.32
MI Blue Shield/MI	11,462,802	6	2.22	19	(.09)
TX Blue Shield/TX	11,146,249	7	2.30	22	(.01)
Nationwide/OH-WV	10,594,251	8	2.35	26	.04
Prudential/NJ	8,251,389	9	2.13	10	(.18)
MA Blue Shield/MA	7,274,434	10	2.31	23	$ .00

While there is no clear relationship between cost per claim and workload size for the contractors who process the largest workloads, there is a relationship for the contractors who process the smallest workloads. Table 2 lists the 10 part A and 10 part B contractors who processed the smallest workloads in fiscal year 1984. The 10 intermediaries had only 3 percent of the total part A workload and the 10 carriers only 4 percent of the part B workload. These contractors generally had the highest costs per claim and cost per claim rankings of their respective groups. Nine of the 10 part A contractors and 8 of the 10 part B contractors had costs per claims that were higher than the national averages for the two groups.

Table 2: Fiscal Year 1984 Costs Per Claim Contractors With the Smallest Workloads

Contractor/State	Workload	Workload rank	Cost claim	Cost claim rank	Difference from national average cost/claim ($6.10)
10 intermediaries with smallest workloads					
Travelers/some providers in MI	168,752	57	$ 9.47	62	$3.37
ID Blue Cross/ID	167,552	58	9.58	64	3.48
Aetna/some providers in WA	166,505	59	8.10	55	2.00
NB Blue Cross/NB	161,804	60	9.54	63	3.44
MT Blue Cross/MT	149,974	61	8.84	58	2.74
Aetna/some providers in NV	147,638	62	6.78	37	.68
DE Blue Cross/DE	144,055	63	6.00	30	(.10)
ND Blue Cross/ND	118,840	64	9.29	61	3.19
HI Blue Cross/HI	114,267	65	9.23	60	3.13
WY Blue Cross/WY	57,082	66	10.19	65	4.09
10 carriers with smallest workloads					
SSS/Puerto Rico	1,377,757	39	$4.83	48	$2.52
MN Blue Shield/MN	1,342,549	40	2.55	36	.24
ND Blue Shield/ND	1,161,194	41	2.11	8	(.20)
Mutual	1,122,985	42	2.50	34	.19
Equitable/New Mexico	930,480	43	2.52	35	.21
Aetna/HI	826,532	44	2.21	18	(.10)
UT Blue Shield/UT	764,864	45	2.66	41	.35
Equitable/ID	622,415	46	2.70	43	.39
MT Blue Shield/MT	574,371	47	2.88	45	.57
Equitable/WY	198,124	48	2.65	40	.34

Chairman **Stark**. You see what I am getting at here.

Mr. **Zimmerman**. Yes; sure.

Chairman **Stark**. How many contractors are there, all together?

Mr. **Dowdal**. Ninety-one.

Chairman **Stark**. Ninety-one. So what you are saying is 10 or 12 of the big ones—I would kind of like to look at them as relative to some of these others.

Mr. **Dowdal**. If I would have to venture a guess today, I would think, from my recollection of looking at that data, that those large ones generally kind of fall in the middle.

Chairman **Stark**. That is all right.

Mr. **Dowdal**. They are near the average on costs per claim.

Chairman **Stark**. Yes; well, they would have to, by virtue of having 50 percent of the business. Mr. Daub.

Mr. **Daub**. Mr. Chairman, thank you very much. I do want to commend you for holding this set of hearings. I have, in the State of Nebraska, as a Member of Congress from the Omaha, NE, area, gone through the trauma, with many, many of my constituents, of a changeover in this business of the processing of payments from one company to another.

We have gone from United Mutual of Omaha to Blue Cross, Blue Shield of Iowa. In front of me I have 14 case histories of what I consider to be very poor processing conduct on the part of the new contractor, and that particular company is a good friend of mine. We have a substantial number of employees in the Nebraska Blue Cross-Blue Shield network, and nationally, I have had the privilege of working with their people on tax reform.

Notwithstanding that, in the conversion, whether it is by standard application of reimbursement procedures and processing as you were discussing a minute ago, or, for other reasons, like for example, lost claims, a substantial number of pieces of paper have just end up with an apology for the paper being lost. Then an attempt has to be made, as you know, to recreate and resubmit the claim.

It has been very damaging to a number of my constituents. I have a number of physicians who have voiced criticism of the current processing of claims and its effects on the people who live in my Nebraska Second Congressional District.

So I do want to tell you that I am most concerned about what seem to be a continuing and recurrent set of problems. Under the current system, I have been concerned for 5 years about the way in which our Government, if we are going to ask private businesses to process what otherwise would likely be double, or three times more expensive for Government to process, and probably three to five times as slow, in my opinion; if we are going to do this contracting out, then we have to also provide adequate reimbursement for handling the paperwork. I suppose over time, what has happened is the volume of paperwork has increased.

That may make the case, but when we ask contractors to monitor these claims, and evaluate them, and not pay what they should not pay, they may look less carefully at the claims because of the inability to afford the overhead of this increasing amount of volume. Perhaps we are not providing them with adequate reimbursement for the effort that we are asking them to make.

Now that is a point of view, not one that I necessarily subscribe to, but I have had that argument advanced. It happens to be the reason why, United Mutual of Omaha decided to no longer participate and give their 1 year notice.

Right or wrong, that is the stated reason. So, for a number of years I have been interested in and concerned about the problem. I am pleased to be on the subcommittee now which has some impact on the matter of contractor reimbursement, as well as the matter of speed, and the accuracy by which these claims are processed. So I intend to continue as a result of these hearings, Mr. Chairman, and take an interest in this matter.

I appreciate what the GAO has done up to this point, to look into the matter, and give us a briefing on what they think is happening. The rundown is appreciated. I do intend to expand upon my concerns as subsequent witnesses appear before us today. Thank you, Mr. Chairman.

Chairman **Stark**. Thank you. Before we finish here, we use the standard bill, right?

Mr. **Dowdal**. Yes.

Chairman **Stark**. Let's take a gall bladder removal which is not too gross to talk about. OK. That is a DRG. Let's call it No. 232. All right? For part A. And let's assume there is only one standard.

Now somebody in the hospital fills out a form, and to me it is a matter of indifference whether that is on paper or in a computer. Same thing. It can get transferred and stored, and filed away.

After they fill out the form at the hospital, I assume I go in and I sit at this little desk and some steely-eyed person looks at me like I am a criminal, and so they want all this information, and then somewhere along the line a bill is generated. What happens to that bill? The hospital then sends it to the contractor? Take me through this a piece at a time.

Mr. **Dowdal**. The hospital sends the bill to the intermediary. The intermediary will then make a determination that it is DRG 232, or whatever.

Chairman **Stark**. Now just for a minute. The hospital keeps a copy of the bill?

Mr. **Dowdal**. Oh, of course.

Chairman **Stark**. All right. The hospital fills it out and keeps a copy of it.

Mr. **Dowdal**. Right.

Chairman **Stark**. All right. And then send it to the intermediary.

Mr. **Dowdal**. Right.

Chairman **Stark**. OK. And the intermediary?

Mr. **Dowdal**. The intermediary logs it in and checks it, makes sure it is all filled out, all the blocks are filled in.

Chairman **Stark**. OK. If the bill is on a Government form, right?

Mr. **Dowdal**. Right. Government-approved form.

Chairman **Stark**. So they are all the same?

Mr. **Dowdal**. Right.

Chairman **Stark**. So the intermediary then goes through the form a blank at a time?

Mr. **Dowdal**. Right.

Chairman **Stark**. All right. And then what do they do with it?

Mr. DOWDAL. They then enter that data, normally into their computer, which verifies it.

Chairman STARK. Let's pretend we do not have computers.

Mr. DOWDAL. Well, then you have somebody sit there and they look at what it says, and they take those various codes that are on there, and they convert those into which DRG it falls into.

Chairman STARK. The hospital does not decide that?

Mr. DOWDAL. No; the hospital can put it down there but the Medicare contractor is the one who is actually responsible for making——

Chairman STARK. Let me ask you this. Does it sound to me like maybe somebody is working over this same form twice? Assuming computers, you punch the numbers into this form, does it make any sense to you, to have the hospital using a different program than the intermediaries, or when the hospital punches the form, if it is blank, they cannot send it to the intermediary?

Mr. ZIMMERMAN. Well, they have to submit a claim. A hospital has to put something down, and they can write down what DRG they think it is, but it is the responsibility of the intermediary to decide what—you know—what to pay.

Chairman STARK. They decide that off this piece of paper?

Mr. ZIMMERMAN. Off the claim; that is correct.

Chairman STARK. What I am getting at is, if the hospital were online to the intermediary, you would only have to enter it once, right?

Mr. ZIMMERMAN. Right.

Chairman STARK. And the computer would kick it out, or you would get a star warning, or something when it was wrong in some way.

Let's assume this bill goes through. What does the intermediary do with that form when they are done with it? Do they send it back here, to HCFA?

Mr. DOWDAL. Electronically, yes.

Chairman STARK. To HCFA?

Mr. DOWDAL. Yes.

Chairman STARK. So HCFA then gets a copy of it.

Mr. DOWDAL. Yes.

Chairman STARK. What do they do with it?

Mr. DOWDAL. HCFA then puts it in their data bases that they use for analyzing things, and determining how much they are going to increase the DRG rates the next year, and a number of other purposes.

Chairman STARK. So this form, this Government form No. 2574, revised by OMB, whenever they revised it, has now had three people operate on it, right? Somebody at the hospital.

Mr. ZIMMERMAN. At least the information on the claim form.

Chairman STARK. Yes. I mean, review it, store it, massage it. The intermediary, and then HCFA again. Anybody else? Does HCFA do anything? Do you guys get it after HCFA and go back and audit it?

Mr. ZIMMERMAN. We could, theoretically.

Mr. DOWDAL. We do not do it with all of them, though.

Chairman STARK. I mean, does that seem——

Mr. ZIMMERMAN. It does not seem particularly unnecessary. I mean, we are talking about a program that pays out some $40 billion a year, part A, and I guess somewhere, we have to store some information that a transaction took place.

Mr. DOWDAL. If this was all being done on paper; one person would type it out and send it some place; somebody else would.

Chairman STARK. Yes, but let's take Aetna just as an example. If you are a privately insured individual under Aetna, or if I am insured under Aetna in my Federal plan, and I go to the hospital to get my gall bladder out, I have a hunch that that piece of paper does not go any place. The hospital sends it to Aetna, Aetna sends them the check, and they do not have an intermediary in there, do they?

Mr. ZIMMERMAN. Well, Aetna is the intermediary.

Chairman STARK. And the payer.

Mr. ZIMMERMAN. Yes; and they are expensive at it in the private business, if Aetna's average is with the rest of the insurance companies—they are paying about 7 percent of their premiums on administration. Of course it includes advertising and other things.

Chairman STARK. Yes, but they are picking up all the overhead—they are paying $7 a claim but they are not paying the HCFA overhead, poor Dr. Bowen's salary, and all. And paying for GAO to audit. I mean, in that seven bucks——

Mr. ZIMMERMAN. That is right.

Chairman STARK [continuing]. You have got one of the big eight accounting firms who is looking after Aetna, and you have completely done away with Blue Cross-Blue Shield—with all due respect to the employees in your district. It just sounds to me as though we are massaging that one piece of paper one whole hell of a lot of times, and nobody is adding anything to it. So that if the program, at the admission desk, were right, that ought to be the last time you "futz" with the thing.

Mr. DOWDAL. Well, theoretically, you could have one central place, where all claims, from all hospitals come in, and they all come in on magnetic media, or across the telephone wires, and all that. Yes, you could have that as one way of doing it. But again, you have to remember there are other functions that they perform besides writing checks.

Chairman STARK. I understand that. Are you going to be around, or do you have to rush off?

Mr. ZIMMERMAN. Excuse me?

Chairman STARK. Are you going to be around for the next hour or so?

Mr. ZIMMERMAN. Sure.

Chairman STARK. I suspect that we might want to ask you a few questions, just as they come up.

Mr. ZIMMERMAN. Fine. Would you want us to sit in the back?

Chairman STARK. Are you on overtime?

Mr. ZIMMERMAN. No. You have us for the whole day and tomorrow.

[The following was subsequently received:]

GAO
United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

May 9, 1986

The Honorable Fortney H. Stark
Chairman, Subcommittee on Health
House of Representatives

Dear Mr. Chairman:

Enclosed are the answers to the questions about Medicare contracting that we were asked to address for the hearing record.

Sincerely,

Michael Zimmerman
Senior Associate Director

Enclosure

1. You stated in your testimony (page 5) that the Gramm-Rudman sequestration in FY 1986 has left contractor funding very tight. In your opinion, is the FY 1986 budget going to be sufficient to pay for the additional 66 million claims that will be processed?

The Gramm-Rudman sequestration reduced contractor funding to the level of the Administration's original budget request which, as I said, was inadequate. We do not believe the contractors will be able to effectively process all the fiscal year 1986 claims within the amount they will receive. Thus, cuts will have to be made and claims processing times and backlogs will grow.

2. According to your study of Medicare contracting, how long is the current average claims processing time? Do you have any projections of what the average claims processing time will be by the end of this year? For FY 1987?

   --Does "average claims processing time" include week-ends?

The following chart shows part B processing times for the period FY 1984 to 1987 for claims submitted by beneficiaries and providers. The times shown for fiscal years 1986 and 1987 are HCFA projections as of March 1986.

Processing time (days):	FY 1984	FY 1985	FEB 1986	FY 1986	FY 1987
Beneficiary claims	12.3	16.6	20.4	38	38
Provider claims	10.9	14.1	16.6	38	38

HCFA currently defines "claims processing time" as the length of time in calendar days from the date the claim is received to the date the Explanation of Medical Benefits or denial letter is prepared. Thus, the average processing time does include weekends, but does not include mailing time nor does it include the time spent in the contractor's check writing process.

3. Are contractors losing money by agreeing to process Medicare claims?

We cannot say for sure that contractors are losing money on their Medicare contracts but there are many indications that they have absorbed some costs. As noted in our report, we came across a number of HCFA documents that show contractors probably absorbed costs and a number of contractors told us that they had, in fact, absorbed costs.

4. You stated in your testimony (page 6) that a lossening of safeguards over program payments is occurring. Could you elaborate on this statement? How are safeguards being loosened?

A number of contractors have told us that they are no longer able to do more than the minimum required by HCFA and have cut back on their safeguard activities. We site specific examples in our report where contractors have or plan to cut back on audit, utilization review, or Medicare secondary payer activities. We also discuss how the cutbacks could affect program safeguards included in the claims processing function. About 30 percent of the cost of claims processing is actually for safeguard activities and good claims processing is crucial to the effective performance of other safeguard activities. Also, many contractors failed CPEP standards in the safeguard areas in fiscal year 1985 and we believe this demonstrates that all is not well in the program safeguard area.

5. In your opinion, does HCFA currently have the authority to conduct fixed-price competitions?

As stated in our report and our testimony, we believe that section 2326 of DEFRA gives HCFA the authority to award two part A and two part B competitive fixed-price contracts during each of fiscal years 1985 and 1986. HHS has interpreted the DEFRA provision as only providing authority to seek competitive bids for cost contracts. One of the primary reasons that we disagree with the HHS interpretation is that HHS already had authority under sections 1816 and 1842 of the Social Security Act before the enactment of section 2326(a) of DEFRA to use competition for cost reimbursement contracts. Thus, we do not believe that it is appropriate to interpret section 2326(a) only as providing authority to use cost reimbursement contracts.

6. What is your overall sense of the Medicare contracting situation? Have contractors been pushed as far as they can be pushed?

During the past few years, contractors have had to adjust their operations to implement numerous legislative and programatic changes and have had to process greater than expected workloads, but the contractor budget has not kept up with these demands. As stated in our report and testimony, we believe that recent budgetary actions have pushed the contractors to the point where their effectiveness has been impaired. This is illustrated by the increasing claims backlogs and processing times, and from the number of contractors who are not meeting HCFA's CPEP standards.

7. What would you consider an adequate level of funding for FY 1987? How can claims volume projections be improved?

It is difficult for us to say precisely what the fiscal year 1987 funding level for the Medicare contractors should be. However, by looking at the experience for fiscal years 1984-86 we can get a range of possible funding levels and a perspective for their adequacy. The following table shows the funds that would be needed to process the projected workload for fiscal year 1987 at a cost per claim equal to that for each of the prior 3 fiscal years.

Workload	Funding at FY 84 cost/claim ($3.14)	Funding at FY 85 cost/claim ($2.82)	Funding at FY 86 cost/claim ($2.56)
		(millions)	
394[a]	$1,237.16	$1,111.08	$1,008.60
411[b]	1,290.50	1,159.02	1,052.16

[a] HCFA Bureau of Program Operations projection

[b] HCFA Office of the Actuary projection

The administration's contractor budget for fiscal year 1987 is $1,006.8 million. Using HCFA's projected workload of 394 million claims, contractors would be paid about $2.55 per claim which is less than they will be paid in fiscal year 1986.

Congress, through the Comprehensive Budget Reconciliation Act of 1985, has authorized an additional $105 million for program safeguards. This could bring the amount paid to contractors to $2.82 per claim--the same amount they were paid for fiscal year 1985. As stated in our report, we believe that contractor funding was inadequate in fiscal year 1985.

Further, while the additional funds would help alleviate our concerns about program safeguard funding, we are still concerned about the amount of funds available for claims processing, particularly since workloads are now expected to exceed the levels projected in the administration's budget. Based on the administration's budget request of $522 million for claims processing and HCFA's current workload projection for fiscal year 1987 (394 million claims), contractors would be paid about $1.33 to process a claim--$.07 per claim less than the fiscal year 1986 amount per claim which we believe is inadequate. The following table shows that the claims processing function has been significantly affected by recent budget cutting.

	FY 1984	FY 1985	FY 1986	FY 1987 (BPO)	FY 1987 (Actuary)
Workload	274	330	363	394	411
Claims Processing Funds	$484	$505	$507	$522	$522
Cost/Claim	$1.77	$1.53	$1.40	$1.33	$1.17

Concerning the workload projections, an internal HCFA task force made a number of recommendations in July 1985 to improve the accuracy of the projections and HCFA has implemented some of them. We have not evaluated the process that HCFA uses to project workloads and, therefore, cannot make any specific recommendations to improve the process.

Chairman **Stark**. That is all right. Our next witness is Kevin Moley, who is the Acting Associate Administrator of Operations for HCFA, and he is accompanied by John Berry, who is the Director of the Bureau of Program Operations. Mr. Moley, you may proceed in whatever manner you like.

STATEMENT OF KEVIN MOLEY, ACTING ASSOCIATE ADMINISTRATOR OF OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY JOHN BERRY, DIRECTOR, BUREAU OF PROGRAM OPERATIONS

Mr. **Moley**. Thank you, Mr. Chairman, and Congressman Gradison.

I have here with me, as you know, John Berry, who is the Director of our Bureau of Program Operations.

We're pleased to be here today to discuss our agency's role in administering the Medicare Program, and in particular our reaction to the General Accounting Office's recently completed report on Medicare contracting and the adequacy of Medicare contractor funding.

We share a mutual concern for encouraging Medicare contractors to perform as efficiently and effectively as possible.

Simply stated, our objective is to gain good contractor performance at a reasonable price. We have used a number of means to achieve this goal and believe that additional improvements in performance and price are quite possible.

At the outset, let me state that as a whole the Medicare contractors have done an outstanding job in implementing program changes in protecting program dollars and in serving beneficiaries and providers. They have done this in an increasingly efficient and professional manner. This program cannot run without them. We want and need their expertise. We want to take this opportunity to publicly acknowledge their contribution and thank them for it.

At present, as has been previously stated, there are 91 contractors in the Medicare Program, 54 intermediaries, 36 carriers, and 1 combined intermediary/carrier.

Under part A, the hospital insurance portion of Medicare, hospitals and skilled nursing facilities are permitted to nominate a private insurer to act as their intermediary in dealing with Medicare.

Home health agencies are assigned by HCFA to regional intermediaries. Effective October 1, 1986, the number of regional intermediaries for home health agencies will be reduced from 47 to 10, in accord with trying to gain more consistency and efficiency in paying home health agency claims about which we will speak a good deal more as the day progresses, I'm sure.

Claims for services rendered by providers are reimbursed by intermediaries directly to institutions. Carriers interact with providers and beneficiaries under part B, the supplemental medical insurance portion of Medicare.

The law provides that the Federal Government should select carriers from within the private health insurance industry to act as the Government's fiscal agent in the processing of claims and reimbursement of beneficiaries, physicians and other suppliers.

In addition to processing claims and making payments, intermediaries and carriers review the medical necessity of claims submitted, identify situations and collect payments where Medicare is not the primary payer, and recover overpayments when it is determined that an incorrect payment has been made.

Additionally, both intermediaries and carriers provide information and guidance to beneficiaries and providers on the administration of the program.

For the most part, carriers and intermediaries are cost-reimbursed subject to the standards established by HCFA.

Total administrative cost to both HCFA and the contractors is now approximately 1.2 percent of total program costs, compared to 1.8 percent in 1980

The ratio of administrative cost to total cost is better than that of the majority of organizations providing health insurance in the private sector.

As the GAO testimony stated, the fiscal year 1986 contractor budget is tight. Congress appropriated $963 million with a $15 million contingency fund. The Gramm-Rudman-Hollings cuts reduced contractor funding to $922 million, with a $14.4 million contingency.

To live within this budget, an increase in contractor claims payment time has been necessitated, from an average payment time at the end of fiscal year 1985 of 15.6 days under part A, and 20 days under part B, to 30 days under both programs by the end of fiscal year 1986. I might add, that we still expect to pay 85 percent of all claims within the 30 days by the end of fiscal year 1986.

Although the slowdown in payment may temporarily inconvenience some providers and beneficiaries, we believe that it is the most equitable methodology to cope with Gramm-Rudman-Hollings reductions.

A delay in payment for fiscal year 1986 will result in Medicare trust fund savings of $71 million in interest under part A, and $62 million in interest under part B. We believe that our fiscal year 1987 contractor budget assures the most efficient and effective operation of the Medicare Program while upholding the high quality of services that beneficiaries have come to expect.

The budget, which would provide $957 million, with a contingency of $50 million for unanticipated workload increases and operating costs, represents a significant improvement over the 1986 situation.

However, we believe that some of the steps taken to live within the fiscal year 1986 budget level, such as increasing the payment cycle, are sound financial management initiatives that should be continued even in a less constrained budget environment.

Although the Prompt Payment Act does not apply to the Medicare Program, it does provide some guidance for consideration. In particular, the act requires the Government to pay bills as close as possible to the 30th day after receipt. This is a dual-edged requirement, acknowledging both the interest, which can be earned on trust fund dollars, and the obligation to pay bills with reasonable promptness.

Given the fact that 6 percent of the Medicare trust fund revenues come from interest, moving to a 30-day cycle earns the trust fund approximately $130 million per year.

The principal impact of such a change would be on the provider community, since 100 percent of part A dollars and 70 percent of part B dollars, or 92 percent of total Medicare outlays, goes directly to providers.

Many providers will not be affected by the 30-day standard because currently over 62 percent of all part A payments are reimbursed through some type of periodic interim payment [PIP]. Forty-eight percent of all hospitals, and 23 percent of all facilities—including hospitals—are on PIP.

Recently, there has been increasing concern expressed by providers about the speed of claims payment, access to contractor staff, and responsiveness of the reconsideration and appeals process.

Home health agencies, in particular, have raised these issues. The concerns appear to stem from a combination of three factors: First, contractors increasing vigilance in applying coverage and reimbursement rules; second, the effect of an admittedly tight budget; and, third, operating problems that unfortunately occur in a system of this size.

Our contractors will process over 350 million claims in fiscal year 1986 from over 17,000 institutions, 450,000 physicians, 75,000 suppliers, and 31 million beneficiaries. Consequently, a problem impacting a relatively small percentage of claims could affect a substantial number of providers and beneficiaries.

Even in the normal operation of the system, as additional emphasis is placed on initiatives to increase medical necessity reviews and identify situations and collect payments where Medicare is not the primary payer, the standard claims processing time will increase.

HCFA is committed to operating the Medicare Program efficiently within the statutory and regulatory parameters.

Our insistence that contractor performance standards be met will require strong management by HCFA and the contractors.

Let me reemphasize, if I may, the size of the system—350 million claims. If those claims were spread evenly, and they are not, over the 435 congressional districts, obviously some, by virtue of the demographics in terms of providers and beneficiaries, will have considerably more than the average, and others, obviously less.

But if in fact it were an average, and one-tenth of 1 percent of those claims generated a complaint, you'd have 8,300-plus complaints in your individual congressional offices as a result of Medicare claims payment alone.

Once again, we think that emphasizes and puts in perspective the enormity of the system in which we are operating.

I would like to discuss now our comments regarding GAO's latest report on Medicare contracting. Since we have provided specific written reactions to every GAO report conclusion, I will simply summarize our responses here.

To begin with, we believe that GAO has misinterpreted the provisions of DEFRA in reviewing HCFA's fixed price contracting authority. GAO concludes in its report that section 2326 of DEFRA authorizes the use of competitive fixed price contracting.

We wish we believed likewise. Although this authority would have been preferred, in the opinion of the Department's General Counsel all that Congress did provide in section 2326(a) is the authority to avoid the provider nomination process in a limited number of contracts under sections 1816 and 1842 of the Social Security Act.

Therefore, any contract awarded by HCFA under the authority of 2326 must be cost-reimbursed, not fixed price.

GAO further recommends that the contractor development process place more emphasis on individual contractor cicumstances than the HCFA cost standards. We believe that we already recognize individual differences——

Chairman STARK. Excuse me a minute. Go back to this discussion on the DEFRA authority. I'm not sure that I was here then, but didn't HCFA participate in writing those regulations when they were written?

Mr. MOLEY. We may have, Congressman, and apparently it has generated some considerable controversy.

Chairman STARK. I understand you have one lawyer who disagrees in your group, but how can you have a fixed price cost contract? What does that mean to you. Fixed price cost. Is that sort of like a right-left-down the middle, or is that——

Mr. MOLEY. Well, almost. As I said, Congressman, we actually would prefer to have the fixed-price contracting authority that GAO indicates they believe the DEFRA provision gives us.

It may be a matter of some technical wording.

Chairman STARK. Are you thereby asking for an amendment? We could probably get that out this afternoon.

Mr. MOLEY. Indeed we are.

Chairman STARK. If, in fact, the legislative counsel doesn't tell us you already have it. I mean, there are some differences of opinion as to whether you have that.

Mr. MOLEY. Correct. Indeed, there is.

Chairman STARK. What is the danger if you don't? What if you proceed as if you didn't have it? What happens to you if you go ahead and do it? What if we're right, that you already have the authority? What harm would it be if you went ahead and used it?

Mr. MOLEY. Well, as I said, our general counsel—and I am not an attorney—but our general counsel assures us that we don't have that authority, and I would presume that in any kind of fixed-price contracting award that took place would very possibly subject us to some legal jeopardy in that instance.

As is often the case in any Government agency, I think it behooves us at this point to follow the direction of our general counsel and simply ask that whatever is necessary to be done, that we ask for it to be done in this regard.

Chairman STARK. You haven't asked for that legislation, you know.

You've never requested that.

Mr. MOLEY. We are at this time, Congressman.

Chairman STARK. You are, as of today, you mean.

Mr. MOLEY. Indeed, we are. And this is generated by virtue of the GAO report that indicates that they believe we have it, and our indication that we don't.

Chairman Stark. Thank you. Go ahead.

Mr. Moley. As I said GAO recommends that the contractor development process place more emphasis on individual contractor circumstances than HCFA cost standards.

We believe that we already recognize individual differences in contractor budget requirements by including in the budget negotiation process adjustments for area wages, bill mix, and levels of part A reconsiderations. We cannot return to the pre-DEFRA budget process where contractors were allowed to set their own reimbursement without cost limitations

The DEFRA authority was used to save over $45 million in contractor funding in fiscal year 1985 alone; a return to the old budget process would be self-defeating and costly.

Furthermore, indications are that our budget negotiation process is working quite well, as evidenced both by the fact that only two contractors have made a decision to leave the program since the use of statistical standards, and that costs per claim have been substantially reduced.

The budget section of the GAO report also contends that payment safeguards and beneficiary services have suffered as a result of budget savings. We strongly disagree. Payment safeguard dollars have been increased approximately 20 percent in each and every budget since fiscal year 1982. Program savings have also increased substantially over this period of time. In addition, beneficiary service dollars have increased over 10 percent in each year during the same period.

In its final conclusion and recommendation, GAO asserts that existing legislative authority should be used to remove consistently poor performers from the Medicare Program. We very strongly agree, and are presently conducting DEFRA competitions under part A in Idaho and part B in New Mexico.

However, we should point out that the goal of performance management is to maintain and improve performance, not simply to remove contractors. We have had significant success in improving the performance of incumbents.

This process is less expensive, and less risky than the removal and replacement of contractors.

Fixed-price contracts, either negotiated or competitive with incentive payments for good performance, would be a most useful tool for moving in this direction.

As we look toward the future, our strategy must encompass building on our accomplishments, flexibility to accommodate program change, the pressure to reduce costs, and the need to maintain a body of work that remains attractive to contractors.

Our fiscal year 1987 legislative proposal asks for the additional authorities that we feel are needed to continue this effort. Specifically, we have requested the elimination of the nomination process in part A, broad authority to compete and negotiate contracts, including the use of other than health insuring organizations, and the authority to reimburse on other-than-cost basis.

The major element which is needed, however, is the ability to operate with fewer restrictions on our contracting authority.

We believe a broader and more normal competitive contracting authority is now appropriate; fixed-price competitive contracts have been proven under Medicare's experimental authority. We strongly believe fixed-price contracts are the best methodology to motivate the kind of performance and price required to operate the Medicare program.

Our management actions over the last few years have been tough and demanding; they are responable and will always be tempered by the fact that this work must remain attractive to private sector contractors.

Similarly, a high level of beneficiary and provider satisfaction must be maintained. We do not contemplate that this work will ever be federalized.

This tempering notion protects our private sector contractors, and our beneficiaries and providers from unreasonable demands being placed inside existing or contemplated authorities.

In our opinion, it is the most prudent way to move the Medicare contracting arena into the future.

I would like to say, in response to your earlier questioning of those representing GAO, that our 10 largest contractors pay 56 percent of our claims. And in our opinion, the authority to compete, although not strictly used to remove contractors, would be extremely helpful to move to larger consortia of claims payers in the interest of efficiency, cost-effectiveness, and overall consistency within the program.

[The prepared statement follows:]

STATEMENT OF
KEVIN MOLEY
ACTING ASSOCIATE ADMINISTRATOR FOR OPERATIONS
HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and members of the subcommittee, I am Kevin Moley, Acting Associate Administrator for Operations, Health Care Financing Administration (HCFA). I am pleased to be here today to discuss my agency's role in administering the Medicare program, in particular, our reaction to the General Accounting Office's (GAO) recently completed report on Medicare contracting and the adequacy of Medicare contractor funding.

INTRODUCTION

We share a mutual concern for encouraging Medicare contractors to perform as efficiently and effectively as possible. Simply stated, our objective is to gain good contractor performance at a reasonable price. We have used a number of means to achieve this goal and believe that additional improvements in performance and price are quite possible.

At the outset, let me state that as a whole, the Medicare contractors have done an outstanding job in implementing program change, in protecting program dollars and in serving beneficiaries and providers. They have done this in an increasingly efficient and professional manner. This program cannot run without them; we want and need their expertise. We want to take this opportunity to publicly acknowledge their contribution and to thank them for it.

The improvements which we have made in program administration have not been achieved without some pain. Ways of doing business have had to be changed in both HCFA and the contractor community. HCFA has set tough standards for price and performance. Contractors have responded with new and improved management techniques incorporating advanced computer systems, improved work flow, and consolidation of data processing. We plan to continue to work together with the contractors to provide the high quality and efficient administration of the Medicare program which we all expect.

BACKGROUND

Before I discuss our reactions to the GAO report, let me first provide a brief overview of the Medicare contracting process. In 1965, when the Medicare program was enacted, Congress adopted as part of the Act an administrative structure which was compatible with the historical pattern of administration used by the private health insurance industry. The Federal Government contracts with public or private organizations to facilitate payments to providers of services and to beneficiaries. These organizations are known as intermediaries under Part A and carriers under Part B. Federal funding for Medicare contractors has increased from $93 million in 1969 to $1.0 billion now requested for 1987.

At present there are 91 contractors in the Medicare program -- 54 intermediaries, 36 carriers, and one combined intermediary/carrier. Under Part A, the Hospital Insurance portion of Medicare, hospitals and skilled nursing facilities (SNFs) are permitted to nominate a private insurer to act as their intermediary in dealing with Medicare. Home health agencies (HHAs) are assigned by HCFA to regional intermediaries. Claims for services rendered by providers are reimbursed by intermediaries directly to institutions.

Carriers interact with providers and beneficiaries under Part B, the Supplemental Medical Insurance portion of Medicare. The law provides that the Federal Government should select carriers from within the private health insurance industry to act as the Government's fiscal agent in the processing of claims and reimbursement of beneficiaries, physicians, and other suppliers. In addition to processing claims and making payments, intermediaries and carriers review the medical necessity of claims submitted, identify situations and collect payments where Medicare is not the primary payer, and recover overpayments when it is determined that an incorrect payment has been made. Additionally, both intermediaries and carriers provide information and guidance to beneficiaries and providers on administration of the program.

For the most part, carriers and intermediaries are cost reimbursed subject to standards established by HCFA. Total administrative costs of both HCFA and the contractors is now approximately 1.2 percent of total program costs, compared to 1.8 percent in 1980. The ratio of administrative costs to total costs is better than that of the majority of organizations providing health insurance in the private sector.

EXPERIMENTAL CONTRACTING AUTHORITY

Although the original Medicare statute permitted only cost reimbursement contracting, HCFA was given limited statutory authority through the 1972 Social

Security Amendments to conduct fixed price contracting on an experimental basis. This authority had its origins in a 1970 Senate Finance Committee report which strongly criticized the inefficient and costly performance of Medicare carriers and intermediaries. The 1972 amendments authorized the Secretary to experiment with fixed price and performance incentive contracts in order to determine whether such contract arrangements could induce more effective, efficient, and economical performance by Medicare contractors.

To date, we have used this fixed price authority to conduct eight experiments. We have learned a great deal from these experiments which will help us to improve Medicare contracting arrangements. Most importantly, our fixed price experiments have shown us that contractors can maintain a high level of service to beneficiaries and providers in a competitive environment with substantial savings to the Medicare program.

DEFRA SECTION 2326 AUTHORITY

Due to our fixed price contract experiments and the increased experience in managing contractors, we have sought the flexibility to administer contracts in much the same fashion as would occur in a typical contracting operation: cost, fixed price, negotiated and incentive contracts.

In response to our concerns to contain contractor costs, and our request for increased contracting flexibility, Congress enacted various provisions in DEFRA which enhance our ability to manage the Medicare contractors. The additional authority granted under Section 2326 of DEFRA enables us to conduct up to four cost competitions in FY 85 and FY 86 to replace Medicare intermediaries or carriers, which over time have been in the lowest 20th percentile of contractors in terms of cost and performance. This authority expires at the end of FY 86. Section 2326 also allowed us to set standards for the administrative costs of our intermediaries and carriers based on the performance of economically and efficiently run contractors.

The DEFRA authorities have been most useful in negotiating budgets and standards with our contractors. Competition allows for the establishment of a market price and performance standard for all contractors. However, our ability to control contractor costs and performance has been hampered because of DEFRA's requirement that procurements be confined to cost reimbursed rather than fixed price contracts. Our only authority for fixed price contracts remains the experimental fixed price provisions of the 1972 amendments.

CURRENT MANAGEMENT STRATEGY

HCFA's contractor management strategy continues to evolve as operating goals are achieved and as the program characteristics of Medicare change. Our approach and our goals must remain adaptable for responding to anticipated program changes and future budget constraints.

As we consider how best to manage the Medicare contractors, we need to keep in mind the considerable success realized over the last few years. Unit costs are down 27 percent in Part A and 15 percent in Part B since FY 83. Expenditures on payment safeguard activities have risen dramatically. Audit expenditures are up 87 percent since FY 82, medical review up 96 percent since FY 83 and a whole new activity of Medicare as a secondary payer has begun. At the same time, a considerable number of changes have been implemented ranging from standard billing forms and codes to the Prospective Payment System (PPS) in Part A and the Participating Physician Program in Part B.

Our contractor strategy flows from the objectives established for our contractors. We are pleased with the progress which has been achieved in each of these areas. These objectives include: the control of program outlays; service to beneficiaries and providers; uniform national management; prompt and accurate response to program change; prompt and accurate flow of data; and reasonable cost of administration.

A number of tools exist which provide our basic day-to-day framework for management. Foremost among these is the Contractor Performance Evaluation Program (CPEP). The CPEP, implemented in 1980, uses standards to measure contractor performance. The development of CPEP has been evolutionary in nature with refinements and improvements made each year often based on contractor input. We believe that CPEP provides a good basis for establishing performance requirements and identifying poor performers. In addition to CPEP, the budget negotiation process, which provides funding against contractor standards, and the workload management system, which integrates change into day-to-day operations, accentuate our management capability.

Our contractor management abilities have been refined since the beginning of the Medicare program. When Medicare was enacted we did not have the experience, knowledge, or credibility with providers to operate the program on a day-to-day basis. Therefore, we had to select private sector insurance companies to perform these and other functions. We now have the knowledge to prescribe in detail contractor functions and have proven that we can competitively select contractors capable of good performance. We have developed and used statistical standards for most elements of unit cost and are proceeding with a contract to develop engineered standards for unit cost. We are reaching the limits of our current authority. The experimental contracts clearly prove more progress is possible with expanded authority.

CONTRACTOR BUDGET

We know that the FY 86 contractor budget is tight. Congress appropriated $963 million with a $15 million contingency fund. The Gramm-Rudman-Hollings cuts reduce contractor funding to $922 million with a $14.4 million contingency. To live within this budget, an increase in contractor claims payment time has been necessitated, from an average payment time at the end of FY 85 of 15.6 days under Part A and 20.0 days under Part B to 30 days under both programs by the end of FY 86.

Although the slowdown in payment may temporarily inconvenience some providers and beneficiaries, we believe that it is the most equitable methodology to cope with the Gramm-Rudman-Hollings reduction. The delay in payment for FY 86 will result in Medicare Trust Fund savings of $71 million in interest under Part A, and $62 million in interest under Part B.

We believe that our FY 87 contractor budget assures the most efficient and effective operation of the Medicare program, while upholding the high quality of services that beneficiaries have come to expect. The budget, which would provide $957 million, with a contingency fund of $50 million for unanticipated workload increases and operating costs, represents an improvement over the 1986 situation.

However, we believe that some of the steps taken to live within the FY 86 budget level, such as increasing the payment cycle, are sound financial management initiatives that should be continued even in a less constrained budget environment. Although the Prompt Payment Act does not apply to the Medicare program, it does provide some guidance for consideration. In particular, the Act requires the Government to pay bills as close as possible to the 30th day after receipt. This is a dual-edged requirement acknowledging both the interest which can be earned on trust fund dollars and the obligation to pay bills with reasonable promptness. Given the fact that 6 percent of the Medicare trust fund revenues come from interest, moving to a 30-day cycle earns the trust fund approximately $130 million per year.

The principal impact of such a change would be on the provider community since 100 percent of Part A dollars and 75 percent of Part B dollars, or 92 percent of total Medicare outlays, goes directly to providers. Many providers will not be affected by the 30 day standard because currently over 62 percent of all Part A payments are reimbursed through some type of periodic interim payment (PIP). Forty-eight percent of all hospitals and 23 percent of all facilities (including hospitals) are on PIP.

The funding level for many aspects of the contractor budget is determined on an individual contractor basis by using statistical standards to determine the reasonable and necessary cost of performance. These standards, authorized by DEFRA, are based upon the actual performance of current Medicare contractors. Claims processing, inquiries, reconsiderations, and hearing and appeals functions are managed in this manner. The use of statistical standards is a common management technique. While they are challenging, they are fair and necessary management tools to establish a cost reimbursement limit.

Other aspects of contractor performance have minimum spending levels or floors established. These floors are used in the payment safeguard functions of audit, medical review and Medicare Secondary Payor recoveries. In combination with specific [illegible] these spending [illegible] assure full performance of payment safeguard activities and maximize the protection of trust fund dollars.

The use of these techniques to determine reasonable and necessary cost of administration, in combination with performance quality standards, provides the basic framework for contractor management.

Recently, there has been an increase in concerns expressed by providers about the speed of claims payment, access to contractor staff and responsiveness of the reconsideration and appeals process. Home health agencies, in particular, have voiced these issues. The concerns appear to stem from a combination of three factors: first, contractors' increasing vigilance in applying coverage and reimbursement rules; second, the effect of a tight budget; and, third, operating problems that unfortunately occur in a system of this size. Our contractors will process over 350 million claims in FY 86 from over 17,000 institutions, 450,000 physicians, 75,000 suppliers, and 31 million beneficiaries. Consequently, a problem impacting a relatively small percentage of claims could affect a substantial number of providers and beneficiaries. Even in the normal operation of the system, as additional emphasis is placed on initiatives to increase medical necessity reviews and identify situations and collect payments where Medicare is not the primary payer, the standard claims processing time will increase. HCFA is committed to operating the Medicare program efficiently within the statutory and regulatory parameters. Our insistence that contractor performance standards be met will require strong management by HCFA and the contractors.

GAO REPORT

I would like to now discuss our comments regarding GAO's latest report on Medicare contracting. Since we have provided specific written reactions to every GAO report conclusion, I will simply summarize our responses here. To begin with, we believe that GAO has misinterpreted the provisons of DEFRA in reviewing HCFA's fixed price contracting authority. GAO concludes in its report that Section 2326 of DEFRA authorizes the use of competitive fixed price contracting. Although this authority would have been preferred, in the opinion of the Department's General Counsel, all that Congress provided, in Section 2326(a), is the authority to avoid the provider nomination process in a limited number of contracts under Sections 1816 and 1842 of the Social Security Act. Therefore, any contract awarded by HCFA under the authority of Section 2326 must be cost reimbursed, not fixed price.

We disagree with a number of other GAO conclusions. For example, GAO concludes that competitive fixed price contracting is not demonstratively better that cost contracting. However, our fixed price contracting experiments have resulted in substantial savings as well as above average performance. The cost per claim is 19.9 percent less for Part A fixed price contractors and 13.6 percent less for Part B fixed price contractors, as compared to cost contractors.

GAO further concludes that there is little justification for changing the provider nomination process. Again, we disagree. Our experience has shown the nomination process to be an unnecessary encumbrance on HCFA's management strategy. There is little justification for retaining the nomination process now that all contractors are required to meet the same performance standards.

GAO recommends that the contractor development process place more emphasis on individual contractor circumstances than the HCFA cost standards. We believe that we already recognize individual differences in contractor budget requirements by including in the budget negotiation process adjustments for area wages, bill mix, and levels of Part A reconsiderations. We cannot return to the pre-DEFRA budget process where contractors were allowed to set their own reimbursement without cost limitations. The DEFRA authority was used to save over $45 million in contractor funding in FY 85 alone. A return to the old budget process would be self-defeating and costly. Furthermore, indications are that our budget negotiation process is working quite well, as evidenced both by the fact that only two contractors have made a decision to leave the program, since the use of statistical standards, and that costs per claim have been substantially reduced.

The budget section of the GAO report also contends that payment safeguards and beneficiary services have suffered as a result of budget savings. We strongly disagree as objective evidence indicates the opposite. Payment safeguard dollars have been increased approximately 20 percent in each and every budget since FY 82. Program savings have also increased substantially over this period of time. In addition, beneficiary service dollars have increased over 10 percent in each year during the same period.

GAO also recommends that contractor incentives be increased to improve payment safeguard performance. We agree that the existing Contractor Performance Evaluation Program can be augmented to place additional emphasis on program safeguards. However, although CPEP changes offer some incentive for better contractor payment safeguard performance, we feel that fixed price contracts with incentive payment will provide the best vehicle for achieving this objective. Instead of intangible bonus CPEP points, actual monetary awards for increased savings and/or transferable ideas would be possible. Furthermore, we intend to develop a program safeguard experiment to test the feasibility of funding a contractor to achieve a maximum amount of trust fund savings.

In its final conclusion and recommendation, GAO asserts that existing legislative authority be used to remove consistently poor performers from the Medicare program. We agree and are presently conducting DEFRA competitions under Part A in Idaho and Part B in New Mexico. However, we should point out that the goal of performance management is to maintain and improve performance, not to remove contractors. We have had significant success in improving the performance of incumbents. This process is less expensive and less risky than their removal and replacement. Fixed price contracts, either negotiated or competitive with incentive payments for good performance, would be a most useful tool for moving in this direction.

CONCLUSION

As we look towards the future, our strategy must encompass building on our accomplishments, flexibility to accommodate program change, the pressure to reduce costs and the need to maintain a body of work that remains attractive to contractors. Our FY 1987 legislative proposal asks for the additional authorities that we feel are needed to continue this effort. Specifically, we have requested the elimination of the nomination process in Part A; broad authority to compete and negotiate contracts including the use of other than health insuring organizations; and the authority to reimburse on other-than-cost basis.

The major element which is needed, however, is the ability to operate with fewer restrictions on our contracting authority. We believe a broader and more normal competitive contracting authority is now appropriate. Fixed price competitive contracts have been proven under Medicare's experimental authority. We strongly believe fixed price contracts are the best methodology to motivate the kind of performance and price required to operate the Medicare program.

Our management actions over the last few years have been tough and demanding. They are also reasonable and will always be tempered by the fact that this work must remain attractive to private sector contractors. Similarly, a high level of beneficiary and provider satisfaction must be maintained. We do not contemplate that this work will ever be federalized. This tempering notion protects our private sector contractors and our beneficiaries and providers from unreasonable demands being placed inside existing or contemplated authorities. In our opinion, it is the most prudent way to move the Medicare contracting arena into the future.

Mr. Chairman, that concludes my statement. I will now be happy to answer any questions that you may have.

Chairman **Stark**. If you follow that string down to its end, why do you state categorically that you'll never federalize the program? I mean, obviously, if 5 is better than 10, 1 is better than 10.

Mr. **Moley**. Well, Congressman, this is against the backdrop of this administration's very strong move toward capitation. As a matter of fact, many of the problems that will be spoken about today, and you related or made earlier comments in this regard, involve paper.

A capitated system—health maintenance organizations, competitive medical plans, and other entities under a volunteer voucher program—would lead to a diminishing of that paper flow.

Chairman **Stark**. It might lead to more programs like you've got down in Florida right now where you may be out of pocket for 150,000 people because the guy may go south with the money. How are you going to deal with that?

Mr. **Moley**. As I indicated, Congressman Stark, in a prior meeting, we believe very strongly that the south Florida situation is atypical, that it does not represent the TEFRA risk contracting process, and it specifically relates to a waiver which we granted.

Chairman **Stark**. I want to tell you: You start giving people $30 million a month and you're going to find that's a very typical sort of thing to happen if you don't have any more controls on the program.

How do those 10 rank in the cost and efficiency terms?

Mr. **Moley**. As you indicated earlier, by virtue of averages, they're pretty much in the average. And that, as you indicated, would have to be expected by virtue of their weight in terms of numbers.

Chairman **Stark**. Let me see if I have the procedures and the history right here. You asked for $935 million for fiscal year 1986.

And when you testified before the Appropriations Committee, you said this would be sufficient. And you also said there would be no increases in the claims processing time, no reductions in payment activities, safeguard activities, and no additional claims backlogs.

Then, the Appropriations Committee appropriated a higher amount. The administration tried to have the additional funds rescinded, claiming they were unnecessary.

So, you got about $1 million more than you asked for, and despite these assurances, you have also instructed contractors to process claims more slowly, and then in your testimony today you blame Gramm-Rudman for the difficulties that have occurred in the claims delays.

Now, you can't have it both ways.

Mr. **Moley**. Well, without having it both ways, Congressman, let me use another term: We're operating here on parallel tracks. One is we very firmly believe that it is in the Government's interest, by virtue of the interest accruing to move to a payment cycle akin to what is required under the Prompt Payment Act, recognizing that the Prompt Payment Act does not apply to Medicare.

Nonetheless, as I said, in the interest of accruing interest, we do believe that moving to paying claims as close as possible to 30 days is appropriate.

Chairman **Stark**. Doesn't that come around the circle? Don't you pay return of capital on operating capital?

Mr. **Moley**. I'm not too sure.

Chairman **Stark**. Yes, OK. You guys are really bright. So you squeeze the contractor on 30 days, I mean the provider. The provider goes to the bank to cover for operating capital, and you guys pay him interest on the operating capital. So you're paying out more interest than you are taking in.

Mr. **Moley**. Remembering, Congressman, however, that 62 percent of part A dollars are paid under periodic interim payment, under PIP.

Chairman **Stark**. OK, explain how the interest thing works to me. I mean, deal with that one on those people who you are squeezing. You guys never get to both ends of the story. You decided that because you're going to save some interest here that nobody else is paying interest over there. And that's a strange and wondrous world you live in over there across the street. But somebody is paying for that money, and in this case, you're paying out of another pocket.

Mr. **Moley**. Well, on the bottomline, Congressman, our actuaries indicate to us that we will have a net savings of $130 million by virtue of moving to this 30-day-payment cycle. It may, in fact, be as a result of the substantial amount, the majority of claims payments on part A being made through periodic interim payments.

Chairman **Stark** Are you slowing down your PIP payments?

Mr. **Moley**. No; we are not.

Chairman **Stark**. Do you intend to?

Mr. **Moley**. No; we do not.

Chairman **Stark**. How often do you pay them now?

Mr. **Moley**. Every 2 weeks.

Chairman **Stark**. You're going to continue that?

Mr. **Moley**. Yes; we are. Congressman, we are, in fact, moving toward setting some standards for periodic interim payment. For instance, 85 percent of all claims must be received by the intermediary within 30 days. However, we do not intend any slowdown of our system to affect or take off any provider who is currently on PIP. That most especially affects home health agencies where we would admit, for a variety of reasons, that we are experiencing a systemic problem in the payment cycle for HHA's.

Chairman **Stark**. Let me ask you this: You review statistically or in an absolute sense all the claims. Do you process all part A claims?

Mr. **Moley**. Through intermediaries, yes, sir.

Chairman **Stark**. No; as an agency. The intermediaries pay out to the providers. What I'm getting at is does HCFA in effect, one way or another, review at some point every claim?

Mr. **Berry**. Yes, all the claims go through the contractors' bill processing system.

Chairman **Stark**. And then do they come to you? In house, do you guys then get them? Do you get a copy?

Mr. **Berry**. We get a sample of information off the claim, but not a copy of the claim itself.

Chairman Stark. You don't store the claims, then? Those are all filed with the intermediary, so that HCFA, in its data processing files, or its files, does not have a copy of each claim paid?

Mr. Berry. Yes, Congressman. Getting back to your earlier question, there is a difference between the claim form and the data set that's on the claim form. The data set does flow through the system.

Chairman Stark. To HCFA?

Mr. Berry. That's right.

Chairman Stark. What's in that data set?

Mr. Berry. An extract of information off the claims form. Beneficiary identifier, type of service, the amount paid.

Chairman Stark. What do you leave off?

Mr. Berry. Some of the details about revenue coding and procedure coding.

Chairman Stark. For instance, things like blood type or family history or——

Mr. Berry. Well, we might pick up the DRG, but we might not pick up the diagnosis and procedure codes that led to the DRG.

Chairman Stark. By the way, you didn't answer my question on appropriations. Are you going to, or are you going to duck that?

Mr. Moley. Not intending to at all, Congressman. In terms of the other track, as I indicated, our interest in moving to 30 days, we do believe this is a tight budget, albeit not a tight budget if all our contractors were operating with the efficiency that our best contractors are, as was earlier spoken about.

Chairman Stark. But you did say to the Appropriations Committee that you weren't going to slow down payments.

Mr. Moley. We have had a signficiant increase——

Chairman Stark. You did say that, didn't you?

Mr. Moley. I'm sure that was a part of the testimony at an earlier time.

Chairman Stark. Why don't you ask for more money?

Mr. Moley. The success of prospective payment, in moving claims from part A, where there generally is one claim that comes from a hosptial, to moving a number of procedures to an outpatient basis, where although they are significantly less expensive, they generate more paper, they generate more claims, has resulted in an increasing trend that has developed a substantially increased volume of part B claims.

Chairman Stark. Have you ever overestimated your volume, ever?

Mr. Moley. Indeed we have.

Chairman Stark. When?

Mr. Berry. I believe in 1983 and 1984, and to some extent in 1985 HCFA's budget estimates ran over actual.

Chairman Stark. No. Volume. Have you ever overestimated the volume of claims?

Mr. Berry. Yes, Congressman.

We did not this year, however.

Chairman Stark. I gather not.

Didn't you basically not ask for as much money as the Appropriations Committee wanted to give you so you wouldn't have to cut back the level of service if you got it, and now you're saying really one of the reasons you have to cut back is because you don't have enough money to provide the service? I mean, somewhere there's been a little slippage there between the Appropriations Committee and today. Is that a fair——

Mr. **Moley**. Absolutely, in all candor, Congressman, that's the truth. Although, as I said, we do believe there is a lot of merit in moving to the 30 day payment cycle.

Chairman **Stark**. Let's talk about my gall bladder again. In that bill, starting from the admissions through the intermediary, into your files which may be used for a variety of statistical information, there is a certain percentage of the information that goes into that billing form that goes right through the system. Isn't that correct?

Mr. **Berry**. Yes, sir.

Chairman **Stark**. What I'm beginning to suggest here is that there are probably a variety of different computer programs. Let's just take the 10 guys who handle the 56 percent. And I guess I'm wondering if there isn't some tremendous amount of efficiency to at least take that standardized stuff and just process it once. I don't really understand why it has to go through all this, why you're paying somebody to handle it. Let's assume it's paper for a minute, but even putting it into a computer takes time. It could almost, it seems—and I'm not suggesting for a minute that you don't need the intermediaries—it could almost come on a direct wire to you, couldn't it? We could use intermediaries to audit, to make exception audits, to ask for refunds if you're overpaying what you're doing anyway. I know that's a major change in the system. But theoretically there's nothing wrong with that, is there, in terms of it could be done. I'm not sure it's right to be done.

Mr. **Berry**. Oh, I think there's quite a bit right with it, Congressman. As a matter of fact we've set aside money in the 1986 and 1987 budgets to move to a standard bill processing system in part A where the software would be identical in all the contractors, and that would enable us to——

Chairman **Stark**. Great minds run in the same direction.

Mr. **Berry**. Yes, sir. Thank you. I consider that flattering.

Chairman **Stark**. Then if you follow that string out, and on the assumption that you guys are going to get your way and go to a national DRG, and now we're using a standard data processing format, shouldn't we just fold a lot of that cost right into the DRG and say look, you get an extra buck or two bucks, or whatever you think, five bucks, and that takes care of the processing.

Then you're only paying for the exception auditing and the review stuff.

Mr. **Berry**. Yes. I think there's a lot of argument for a standard cost for processing various types of claims. As a matter of fact, we've just awarded an industrial engineering contract to help us segregate the cost by claim type.

Chairman **Stark**. I hope it's to nobody on your staff, or no relatives. We've got a little problem with that.

Mr Berry. No, sir, to the best of our knowledge it's not. We'll have that information by this fall that should enable us to know specifically what's the cost of a hospital claim vis-a-vis an SNF claim or a home health agency claim, and adjust the contractor budgets accordingly. Obviously different types of claims cost different amounts to process and we should recognize in the budget that phenomenon. The notion of a standard rate that we would pay the contractors for processing claims has a great deal of appeal. We're fairly close to that now, and I think this additional information will help us get there.

I guess what some people call a statistical standard others might call a standard rate for bill processing.

Our notion is that, particularly on the part A side, the processing steps are similar, and we're going to make them uniform. If that's the case, then our price should be the same, adjusted by wage index, or perhaps by differences in bill mix from contractor to contractor.

Chairman **Stark**. Or just electronic transmission. I mean, if you're not having to do the review, and the claims adjustment there seems to me to be no geographic reason. You can do it as well in Texas as you can in Maine. And it's all wire transfer.

I don't know what percentage of your costs are on that side of it. But we can get at that later.

Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman.

You mentioned in your testimony, Mr. Moley, and in answer to some questions from our chairman, several changes in legislation that you would like us to consider.

You did not mention extending the Prompt Payment Act to the Medicare Program, which I, at the outset of this hearing, alluded to.

Wouldn't that be a useful means of at least providing some protection for beneficiaries, providers, and suppliers since you say you're following the principles of it anyway. Why not make sure you follow the letter of it?

Mr. **Moley**. We believe there is—unlike the Internal Revenue system analogy that you previously made, Congressman—a defect in applying it to Medicare by virtue of the fact that, as you know, interest payments are called for after 45 days. In this case, generally the reasons why claims have not been processed, on average, over 45 days, would be because they are in development. We are looking at them in regard to whether or not Medicare should be the secondary payer, not the primary payer. We're looking at them in regard to medical audit.

So, in fact, we'd be penalizing ourselves on large numbers of claims that are over 45 days by virtue of reasons that we believe are adequate to justify why they're not being paid

As I said, looking into whether or not there is someone else who should be the primary payer, and to whether in fact the charges are well defined.

Mr. **Gradison**. But you, yourself, have mentioned, for example with regard to home health that there are, to use your phrase, some systemic problems.

I guess there are, since as I've mentioned earlier, one durable medical equipment manufacturer in my district, a rather large company, has told me that they are 120 days in some cases, and there's no argument about who's responsible. The payment just isn't coming in.

It would seem to me, whether it should be 30 or 45 days, or whatever the number should be, that if we were to have such a requirement, that it isn't that it would necessarily speed up the payment, but it would keep the provider whole.

I guess what bothers me is if OMB—which I assume is the unspoken party responsible for these policies—comes in and says move to 30 days this year, why can't they say in a couple of years move to 60 days?

I mean, what is there to stop that? I think that perhaps it would not be inappropriate for the legislative body to indicate how many days it considers fair, because I think without a ceiling, the history is pretty clear that the number of days is going to continue to get moved up unless we call a halt to it.

Could you not go to 60 days, under present law, if you decided, as a matter of policy, to do so?

Mr. MOLEY. Congressman, I think the only way I can answer that is by saying that the Prompt Payment Act, and the 30-day cycle that it generates, we think is very akin to the way business is generally conducted commercially across this country.

Consequently, we don't think it places an undue burden on providers, or the 30 percent of part B claims we pay to beneficiaries. I'm sure that, were we to go to anything substantially longer than that, that more heat might be generated than light, with the appropriate repercussions that that might entail.

Obviously, as I've indicated, we believe that it is in the interests of good business practice, in order to accrue interest to the Medicare trust fund, to go to that 30-day cycle. We do however, understand that we have, and we are working on, systemic problems in the areas of both DME and payment to home health agencies.

Mr. GRADISON. Well, I'm just suggesting, Mr. Chairman, that maybe we can help to reduce that risk, that the heat will reach that point by making it impossible for it to reach that point.

I mean, frankly, my sense of it is that you get caught in the middle on these things, between the program responsibilities which the law requires you to carry out, and the pressures from OMB which is trying to deal with a difficult budget situation. I'm not trying to put words in your mouth. That's just my sense of it.

And to the extent we can, by statute, indicate just what the ground rules are, I think everybody's better off. I won't pursue it further at this point. But thank you, Mr. Chairman. And thanks for your very useful testimony, Mr. Moley.

Chairman STARK. Could I just come back on Mr. Gradison's line for a moment before I recognize Mr. Pickle. Do either of you know of any concern or any discussion or any indication that the funds for Medicare contracting could run out before the end of the year?

Mr. MOLEY. I think, Congressman, that given the budget with which we are presently living—that is, the $922 million plus $14.4 million in contingency—the chances of that happening are quite negligible if, in fact, the contractor community cooperates with us in moving to a 30-day payment cycle gradually between now and the end of this fiscal year.

Chairman STARK. And if they don't, what happens if you run out of money? What are you going to do? What is your present plan if you don't make it? If they don't cooperate, what are you going to do?

Mr. **Berry**. I don't think we have any reason to feel that the contractor community will not carry out valid HCFA instructions under their contract.

Mr. **Moley**. Furthermore, Congressman, we believe that we are on the right side, literally and figuratively, of a very fine line between being able to manage this contractor——

Chairman **Stark**. I said that, but you're certainly good enough managers to have a contingency plan. What is it?

Mr. **Moley**. There was some lubricity, if you will, delivered to us in the form of COBRA and some possible relief that that might entail. But the agency and the Department are only now having an opportunity to look into that.

Chairman **Stark**. Wasn't the COBRA money for auditing, and not for claims review?

Mr. **Moley**. That's correct. But as has been previously testified by GAO, we in fact deferred some audits to fiscal year 1987 as part of our fiscal year 1986 planning.

Chairman **Stark**. You haven't asked for the release of the $14 million contingency fund yet.

Mr. **Moley**. Not as yet.

Chairman **Stark**. When do you intend to ask for that?

Mr. **Moley**. We would expect the that decision as to whether to ask for it will probably be made within the next month.

Chairman **Stark**. What do you mean as to whether to ask for it? Are you suggesting that if you ran out of money you wouldn't ask for it? Is there any condition under which you were running short of your claims processing money that you would not ask for that?

Mr. **Moley**. No, Congressman, there is not.

Chairman **Stark**. Has there been any discussion or consideration given to stretching out payments if in fact you run out of money, including the contingency fund?

Mr. **Moley**. Currently, even taking into account the trend we're seeing, which is building increased volumes of part B claims, we very strongly believe that we'll be able to pay 85 percent of all claims within 30 days at the end of fiscal year 1986.

Chairman **Stark**. I understand that. That's not responsive. I said has there been any discussion or consideration given to stretching out the payments as a way to make up any shortfall if, in fact, you do run out of money?

Mr. **Moley**. I'm sure—there have been such discussions. Yes, Congressman.

Chairman **Stark**. So it has been considered as an alternative?

Mr. **Moley**. Yes, it has.

Mr. **Berry**. Congressman, to amplify on that, our worst case volume estimate scenarios coupled with the current unit costs that are in place can be covered inside the existing contractor budget and the contingency fund.

It would take an event that no one anticipates right now to drive volume to the point where we cannot cover it. There are some contractors that have mentioned that they're tight in budget money. We're in discussion with those contractors now, and I think such an action is a typical management process that you go through when you have a tight budget in place. If a contractor says "I'm short," we sit down, we work it out with them. If we concur, we provide the money. If we nonconcur, we say we're sorry, but our standard stands. And by your contract, you must adhere to it.

Chairman Stark. Mr. Pickle?

Mr. Pickle. Mr. Chairman, I have two questions. In the supplemental up today, is there any funds requested by HCFA for any additional appropriations, do you know?

Mr. Moley. Not for the contractor budget, no, Congressman.

Mr. Pickle. I assume the reason you're not asking for additional funds is that you have had a slowdown in payments and you have saved, what, $71 or $62 million in interest by slowing down the payments.

Therefore, you don't need any extra money.

Mr. Moley. Correct, Congressman. As we previously testified, we believe that it is good business practice to move to a standard akin to what the Prompt Payment Act calls for, even though the Prompt Payment Act does not apply to Medicare.

Mr. Pickle. You say it's good policy, then, whereas in 1984 you had a processing time of 12 days, and now in 1986 you've got 20 days? Now you want to go to 30 days, so instead of asking for more money, you're just stretching out payments. That's what it amounts to, isn't it?

Mr. Moley. Congressman, that's the bottomline. But I must say that in regard to that bottomline, we also accrue substantial interest to the Medicare trust fund by moving to that 30-day cycle.

Mr. Pickle. And the question we have to ask ourself, is that fair policy? It may save money, but is that fair to the beneficiaries, and that's something we have to decide as a Congress.

I asked you about the appropriations, because today in the supplemental bill, either today or tomorrow, the Internal Revenue Service is asking for $340 million in extra funding. For all of 1984 they stonewalled the question of whether they needed extra money, and they said no, they don't need any money. Now, they've got to get $340 million extra. They've reversed themselves 180 degrees, and actually are working people now illegally over the country because they desperately have to have funds.

Now, it seems to me like that's terribly poor policy to just refuse to ask for sufficient funding and then a year later come running in a panic and say we've got to have extra funds.

So you're not doing that, but you're doing it by just slowing down payments.

Mr. Moley. Well, we're moving to a-30 day payment cycle. Yes, sir, Congressman. I might add, however, that we highly commend the President's fiscal year 1987 budget which we believe provides an adequate amount of funding for the contractor budget, an increase to $957 million with a $50 million contingency.

Mr. Pickle. Well, let me ask you one other question separate and apart from these policy decisions.

You decided to move the office of HMO over to HCFA. Are you going to have a separate office? Has that been asked? Is it a separate department you're going to have? Will you have enough money to pay for them?

That's a tremendously growing area.

Mr. **Moley**. It's been felt that since there was substantial HMO activities already being conducted in HCFA, that it was in the interest of the Department to move the Office of Health Maintenance Organizations to HCFA where we would have in one area of the Department all activities that health maintenance organizations and other prepaid operations are generating.

My understanding is, although Dr. Roper is today in the process of a confirmation hearing, that that office will report directly to the administrator by virtue of his interest in moving as quickly as possible to competition through capitation.

Mr. **Pickle**. Well, my question is do you have staffing for that agency? It is growing so fast that just moving over to HCFA doesn't solve anything except just moving them out.

The question is will they have personnel to actual handle this fast growing area?

Mr. **Moley**. In fact there's a regulation in process which would develop user fees for organizations that want to become federally qualified. It is our understanding that a substantial portion, if not all of the operating budget for the Office of Health Maintenance Organizations, will be paid for in fiscal year 1987 through those accounts.

Mr. **Pickle**. So you're not asking for additional funding just because of that transfer of HMO over to HCFA.

Mr. **Moley**. Not to the best of my knowledge, Congressman, but I must confess that that is not an area on which I am the final authority.

We will be glad to get the answer for you.

Mr. **Pickle**. I would appreciate it.

[Information follows:]

The Administration is currently reviewing how much, if anything, the transfer of the Office of Health Maintenance Organizations to HCFA will cost.

Chairman **Stark**. Mr. Daub.

Mr. **Daub**. Thank you.

I think that you were in the room when I expressed my concerns with respect to the way in which claims are being handled, and I would like to simply ask you to look into the concerns I have with respect to the Iowa Blue Cross-Blue Shield claims processing.

I was skeptical in the beginning, I must confess that the abundance of beneficiary complaints that I was receiving were simply because of the newness of the transactions, and because of the change of processors.

But I am now convinced, after looking at a number of these cases, that it seems to be more than that, and I do not find the new contractor as responsive. Maybe there are good reasons for it, but the fact of the matter is that there are sure going to be a number of claims falling outside the guidelines on time that we are talking about right now. And I would like the Department to take a quick look into that and perhaps they could be helpful to that contractor. It certainly would be helpful to my beneficiaries.

Mr. **Moley**. We will be more than glad to look into that, Congressman.

Mr. **Daub**. I have no other questions, Mr. Chairman. I appreciate the administration's candor and their view of the things that they are going to have to be doing to plan and accommodate this growing area, within HCFA.

Chairman STARK. I guess I understand your earlier comment about the administration not wanting to federalize things that that is a part of their overall policy. All that I would suggest if there is anybody in HCFA or HHS that ever plays the devil's advocate, that one of the sure ways to federalize, could be by pushing toward vouchers and developing a bunch of HMO's like those in Florida, who really screw up and you could force us to federalize. And then it is a slam dunk. I mean I would not have to introduce a bill. I would have everybody in here screaming and we would federalize the system so fast it would make your head spin. You know, I am not going to introduce a bill to do that, I doubt Senator Kennedy is either. We tried that what, 10 or 15 years ago

Only because you know you can squeeze it so far and pretty soon you build a constituency. Not only the AARP but you are going to have the hospitals and the AMA, if you can believe that, saying let us have a federal system. When that day comes, you will know that you went too far. You know I do not have the votes and I do not suggest it as something that I am dying to do because I want to see socialism grow in the United States, but I am suggesting that you cannot stretch people out. The guys in Florida are screaming that they are not getting paid for 18 months. And I just submit to you that it is just like freezing costs, it works for a while, saves some money but after, you kill the whole program. If you run out of money are you going to stretch payments out further?

It should be obvious to you that we suspect that you are. When the political reaction to that comes, this committee has generally moved in a fairly bipartisan manner. Just a word of warning, I am not necessarily directing it at the witnesses, but to whomever might listen to it. There are HMO's that have been associated with nonprofit institutions that have developed gradually over the years. They have developed some tradition, and they developed some stature in the community. And there is a reputation. But you guys are putting out a hunting license for every schlock entrepreneur in the country to start picking up. It would take me about 15 minutes to go through the census data and pick the 5, or 10 or 15 premiere counties in this country and hand you your lunch because I could make a fortune getting 85 or 95 percent or whatever you are going to offer in a voucher if I could just cherry pick.

And then I have got this cash flow and no real responsibility. I could go south with that money and buy yachts and airplanes, and villas in Europe and you have got nothing in your regulations to prevent that.

And sure, you could audit, you could sit there all day and tell me these guys are stealing the money. I am not referring now to any particular HMO. But as a whole, you are not ready for it, and you are not going to just move it into another department. Insurance companies generally have been living with a lot of reputations. State insurance examiners are used to dealing with an insurance company treasurer who does not buy junk bonds. There has been a tradition just like trust department officers, there is no law that says that they have to buy quality stocks, but generally they have. You have got no tradition, no sort of operating procedures for these guys to combine both good quality procedures on a technical sense, and fiscal responsibility. I think unless you get some of these problems solved, to push that way, you just are asking for trouble—not that you do not have the brilliance to understand, you just do not have the people there to deal with this.

So, I warn you.

Mr. Moley. Congressman, we recognize the validity of a lot of what you have just related. And we are looking forward to working actively with your committee to develop some interim sanctions——

Chairman Stark. You guys police it, we should not be doing that.

Mr. Moley. We will be coming forward with legislative proposals.

Chairman Stark. We will give you the authority to be as flexible as you want and creative as you want. We do not want to give them a license, Mr. Daub.

Mr. Moley. Within the philosophical limits of this administration.

Chairman Stark. Thank you both, very much.

Our next witnesses will consist of a panel, J. Bruce Cardwell, executive vice president of the Blue Cross & Blue Shield Association, and Luther E. Carter, vice president of the Travelers Insurance Co., accompanied by Arthur Lifson, who is vice president of the Equitable Life Assurance Society.

Gentlemen, welcome to the committee and if you would like to proceed in the order that you show up on our witness list, to summarize or expand on your written testimony you may proceed in whatever manner you are comfortable.

Mr. Cardwell, you are up first.

Mr. Cardwell. Thank you, Mr. Chairman.

STATEMENT OF J. BRUCE CARDWELL, EXECUTIVE VICE PRESIDENT, BLUE CROSS & BLUE SHIELD ASSOCIATION

Mr. Cardwell. My name is Bruce Cardwell, and I am executive vice president of the Blue Cross & Blue Shield Association, headquartered in Chicago. To my left is Mr. Harry Cain, who heads our Federal programs division.

I will just summarize very briefly the key points in our opening statement and in so doing I will try to respond to the questions raised by the committee when it called this hearing.

I would like to request that our statement be introduced into the record, and in addition, we would like to offer our comments to the GAO report for the record.

Chairman Stark. Without objection not only will all of the prepared testimony be made a part of the record but the staff has asked me if we will hold the record open, there may be some written questions both to GAO and to HCFA and to the other witnesses, and the Chair would appreciate it if those questions could receive a response and be made a part of the record. Please proceed.

Mr. Cardwell. Thank you, Mr. Chairman.

Let me focus very specifically on the questions that have been raised as we understand them. First, starting with the adequacy of Medicare contractor funding. I will not recite all over again the statistics that have been put in the record. I will just say two things very briefly. The funding for 1986 is inadequate. Of the $978 million that had been appropriated, only $920 million has been allocated to the contractors and it is, indeed, inadequate. The amount requested by the administration in 1987, in our opinion, is even more severely inadequate and it is our estimate and I think that this is an estimate that my colleague to my right would share, that as a minimum this program will take $1,150 million to administer given the growth in workload that we anticipate for 1987.

I was also very interested in your question about whether anybody ever underestimates the workload? It has been our experience that the Government tends to underestimate it. They sometimes, perhaps, accuse us of overestimating it.

Next is the question of the effect of HCFA's instructions to contractors that claim backlogs be allowed to build up. If I serve no other useful purpose——

Chairman STARK. Excuse me, you did receive those instructions did you not?

Mr. CARDWELL. Yes, indeed.

Chairman STARK. I mean you were told by HCFA that you should let——

Mr. CARDWELL. I do not think that is in question.

Chairman STARK. OK.

Mr. CARDWELL. If I serve no other useful purpose today, it would be to try to point out to you that there is a difference, a mechanical difference, and a management and decisionmaking difference between pacing the rate at which I pay a claim and the pace at which I process a claim. I can regulate the pace of claims payment without slowing down the pace at which I process claims. They are two different functions. And in the conversation so far today, the two have been melded together as if they were one and the same thing.

It is our opinion, and we feel it very strongly from 20 years of experience with this program, that it is a serious mistake to delay claims processing both in terms of what it will ultimately cost in future administrative costs and in terms of its impact on beneficiaries. In particular, it is just unthinkable that an administrator of a program like this would deliberately hold back in the processing of claims as distinguished from the payment of claims.

This, clearly, in our opinion, is a case of somebody cutting the cloth to fit the budget. We have to sympathize with the contention that was made earlier that the administrators of the program are in a bind. On one hand they are under tremendous pressure to reduce the net cost of this program, and on the other hand, they have a responsibility to the programs contituency. And the next question deals with the effect of Gramm-Rudman-Hollings. Again, I will not burden you with statistics.

In 1987, should the automatic cuts be triggered, they would reduce the amount available against our estimate of what is required by about $200 million. Taken against the amount that the administration has requested, it would be a reduction of about $180 million. Both are significant differences.

Next, the use of the Deficit Reduction Act of 1984 competitive bidding authority. We agree with the General Accounting Office report in its conclusion that general competitive bidding of the administration of this program would be a serious mistake. We think that HCFA has adequate authority and that it should exercise that authority, and concentrate on poor performers.

On the use of cost caps, again we think that it is a serious mistake and a case of cutting the cloth to fit the budget. We have no objection to the concept of caps, except on two counts. One, we think the literal terms of cost reimbursement contracting have been corrupted by them. What you really have today, in effect, is a fixed price contract parading under the guise of a cost reimbursement contract. But more significantly, the more serious mistake, in our judgment, is the application of a cap to both the top of the scale and the bottom of the scale. The most efficient contractors are subject to a cap. It does not make any sense.

That concludes our remarks. Thank you.

[The prepared statement and attachment follow:]

TESTIMONY

J. Bruce Cardwell

Executive Vice President

BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman and Members of the Subcommittee, I am J. Bruce Cardwell, Executive Vice President for the Blue Cross and Blue Shield Association, the national coordinating organization for all of the Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield organization has been deeply involved in Medicare since the program's beginning 20 years ago. Under contracts with the Health Care Financing Administration, our Association and member Plans serve as Medicare intermediaries and carriers responsible for the day-to-day administration of the program. We process 85% of all Medicare Part A bills, including nearly all hospital bills, and 62% of Part B claims, and are committed to the cost effective administration of this important program.

The Subcommittee has requested comments on a number of issues related to the General Accounting Office (GAO) report "Medicare Contracting: Existing Authority Can Provide for Effective Program Administration", including:

-- The adequacy of Medicare contractor funding to support a growing volume of claims and the implementation of program changes;

-- The effect of HCFA's instructions to contractors that claim backlogs be allowed to grow and that claims be processed more slowly on Medicare assignment rates, participation, provider cashflow and beneficiary liability;

-- The potential impact of FY 1987 Gramm-Rudman-Hollings cuts on Medicare contracting and the Administration's FY 1987 budget request for Medicare program administration;

-- The use of Deficit Reduction Act of 1984 competitive bidding authority;

-- The use of "cost-caps" to constrain payments to Medicare contractors, and their impact on erroneous payment rates.

In addition to these issues, we would like to comment on the current system of evaluating contractor performance, which is also addressed in the GAO report. Before commenting specifically on each of these issues and providing our recommendations for change, I would first like to provide an overview of the Medicare contractor environment and identify some of the major tasks that contractors, working with HCFA, have accomplished.

The Medicare intermediary and carrier contractor structure has served the program and its beneficiaries extraordinarily well over the last 20 years. Medicare contractors' administrative costs, expressed as a percentage of benefit payments, have long been extremely low. They now represent about 1.3% of total Medicare expenditures and are continuing to decline. Medicare administrative costs have also declined significantly on a per claim basis. For example in FY 1978, the average cost of processing a claim was $4.06 for Part A and $2.84 for Part B. For FY 1986, HCFA estimates that unit processing costs will be $2.00 for Part A and $1.76 for Part B. Although we believe that the FY 1986 levels are too low to meet actual workloads our recommended funding levels for this year would also have shown a significant decline from prior unit cost figures. We know of no other long standing government contracting arrangement that rivals this level of efficiency.

In addition to its efficiency gains, the contractor system has been extremely effective at controlling Medicare benefit payments, responding to and dealing with beneficiaries and providers, and implementing complex legislative, regulatory, and administrative policy changes, all while coping with an ever growing volume of claims.

As this Subcommittee has recognized when it recommended additional funding for audit and utilization review activities, Medicare contractors play a major role in the direct control of program expenditures. For example, HCFA estimates that contractor efforts in provider audit, medi-

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cal and utilization review, and third party liability collections will save over $1.7 billion in FY 1987. The payback ratios on these activities, in terms of benefit dollars saved versus administrative dollars spent have ranged from 5:1 to 30:1 based on the type of activity performed. Contractor claims processing activities also generate considerable savings on their own by assuring that only covered services are reimbursed, that duplicate and erroneous claims are denied, and that payment amounts are accurately determined. HCFA estimates that these activities return almost 8:1 in benefit savings, for more than $8 billion in savings in FY 1987. In addition, these activities serve as the foundation for all other program safeguard activities.

Medicare contractors are also the program's front line in dealing with over 33 million beneficiaries, 400,000 physicians, 7000 hospitals, 6,000 skilled nursing facilities, 5,600 home health agencies, 3,500 laboratories and other providers. These activities include not only processing about 343 million claims in FY 1986 but also responding to inquiries and communicating program details to those most affected by them.

With respect to the implementation of complex program changes, the Subcommittee is no doubt familiar with the monumental task that contractors and HCFA accomplished in implementing the Medicare prospective payment system (PPS) for hospitals under extremely short deadlines. We would also note that PPS was put in place, and is now being administered, at a time when numerous other programmatic and administrative changes were taking place in Medicare. Since 1983, without taking into account the recently enacted reconciliation measure, Medicare contractors have had to respond to at least 50 fundamental changes, including the implementation of a uniform provider billing form; secondary payer initiatives; the physician fee freeze and participation program; and changes in laboratory and durable medical equipment reimbursement. In total, contractors have implemented more than 800 changes during this period. Our detailed comments on the draft GAO report, which I have submitted for the record, lists additional examples.

To implement these changes, contractors often must make costly modifications to their claims processing systems; revise audit and utilization review procedures; train staff; communicate with providers and beneficiaries through newsletters and responses to written and telephone inquiries; and reallocate resources away from other important initiatives and ongoing activities

Severe funding restrictions, current budget priorities, overly restrictive interpretations of current statutory authorities, and the unpredictability of administrative policies combine to threaten the continuation of this record of success.

With this overview in mind I would now like to address specifically the issues raised by the GAO report.

Adequacy of Medicare Contractor Funding

Early this fiscal year, we were convinced - as were others, most notably the GAO - that the FY 1986 contractor funding would not be sufficient. Although the Congress specifically recognized the problems inherent in inadequate funding and therefore provided a higher level of funding than the Administration had originally requested, the Gramm-Rudman-Hollings legislation forced a reduction of $41 million from the appropriated amount. This year, the Administration proposed a further cut of $2.1 million in the FY 1986 funding level -- in the form of a rescission request -- in an effort to assure that the actual funding level did not exceed their original budget request.

In comparison to the $978.5 million Congressional appropriation, contractors are now operating under an unrealistically low FY 1986 budget of $920 million. This amount is $12 million less than the amount allocated for FY 1985, while claims volumes that have grown by 31 million and inflation has increased by 3.9%. The effects of inadequate funding are surfacing. In an effort to cope with this shortfall and to increase the interest earned on Medicare Trust Fund monies, HCFA has directed contractors to process claims more slowly and to increase claims backlogs. For the first 5 months of FY 1986 the Part B claims backlog has increased by 37% over the level in FY 1985. Part A has seen an increase of 18% in bill inventory.

The President has signed the Comprehensive Omnibus Budget Reconciliation Act of 1985 (COBRA) which includes provisions for additional funding for certain contractor functions for FY 1986 and subsequent years. This funding is critically important and we applaud this Subcommittee's efforts that lead to the enactment of this legislation. This additional funding, however, is earmarked for certain activities other than ongoing claims processing. An additional $60 million annually was made available for the next three years for audit, medical and utilization review and Medicare secondary payer activities and $18 million was authorized this year for activities relating to the participating physician and fee freeze provisions. While the availability of these new earmarked funds conceivably could enable a reallocation of existing funds to eliminate the shortfall in claims processing, HCFA has not yet announced how, if at all, it will allocate these new monies. We would expect that at least $20 million of available funds will have to be reallocated to implement changes in COBRA. Based on the budget policy that seems implicit in the Administration's rescission request and its objective of saving interest on Trust Fund monies by directing contractors to process fewer claims than they receive, we doubt that any significant funding will be directed to ongoing claims processing activities.

Effects of Increased Claims Backlogs

Increasing claims backlogs have a number of adverse effects on the program, beneficiaries and providers. Before addressing these effects, I would first like to clarify the difference between claims processing cycles and claims payment cycles.

Claims processing runs from the receipt of a claim to the point where a claim is approved for payment or denied. That process is costly under any circumstance, and is adversely affected by large backlogs or inventories of claims.

Claims payment cycles, on the other hand, can be set at any interval the government would like; one does not have to (and should not) slow down claims processing in order to slow down claims payment.

In the current year, HCFA has not allocated enough funds to contractors to process all the claims that will be received. This will result in rising inventories of unprocessed claims (which are measured primarily in terms of "days work on hand" or numbers of "claims pending over thirty days"). HCFA has recently relaxed contractor performance standards so that such rising inventories will not reflect badly on the contractors.

At current funding levels, by the end of FY 1986 Part A intermediaries will have 16 days work on hand with a conservative estimate of 1,062,000 bills pending over thirty days. Part B carriers are likely to have 18 days work on hand and 2,676,000 claims pending over thirty days. Contrasted with the fourth quarter of 1984, Part A bill inventories pending over 30 days would have increased by 530 percent, while overall Part A inventories would have increased by 259 percent. Part B claims inventories over the same period pending for over 30 days would have increased by 163 percent while overall inventories would have increased by 161 percent.

While HCFA's policy and funding decisions are most responsible for this increase, it should be recognized that the plethora of changes that contractors have had to implement concurrently over the last few years and unexpected increases in claims volumes also play a role. The national average inventory levels are also affected by performance difficulties that any contractor may experience on a temporary basis.

Rising inventories do affect "average processing time," though the impact is not felt immediately. At the end of FY 1984, the average processing time for all Part B claims was 12.5 days. In the first quarter of FY 1986 this figure was 15.3 days and further increases are expected by year end. For Part A, average bill processing time at the end of FY 1984 was 7.3 days for inpatient hospital bills, 8.5 days for outpatient bills, and 12.1 days for SNF and HHA bills. In contrast, the average processing time in the first quarter of FY 1986 increased to 9.0 days for inpatient bills, 15.9 days for outpatient bills (almost double the prior level), 21.7 days for SNFs and 22.5 days for home health bills and, again, further increases are expected.

Average processing time, however, only counts days from receipt of the claim to when it is approved for payment or denied. After a claim is approved for payment it then spends several days in the contractor's check writing process, which is usually on weekly or a bi-weekly cycle. Depending on the contractor's processing system and the U.S. Mail, this step can add from 4 to 9 days to the total time it takes for the beneficiary or provider to receive the check. As a result, for many types of services, Medicare already is paying claims close to about 30 days after receipt.

The effects of slower claims payment will vary significantly based on whether the claim is filed directly by beneficiaries (i.e. unassigned claims) or by providers. In addition, different types of providers and the same types of providers with differing circumstances will experience quite different effects.

Claims payments on unassigned claims are likely to be affected the most. These claims are more difficult to process than assigned claims because they often contain incomplete information. In the first quarter of FY 1986 the average processing time for unassigned claims was 17.9 days vs. 14.1 days for assigned claims. In addition,assigned claims often are received and processed electronically and it is difficult for contractors to slow this process down artificially. Consequently, the claims filed by beneficiaries directly will bear a disproportionate share of the delay in claims payment.

Physicians and suppliers will also be affected greatly by the claims payment delay on assigned claims. The reduced cash flow will make it more difficult for them to meet payroll and to pay their bills timely. When payment is not forthcoming, these providers may begin to submit duplicate bills, thus producing additional workloads for an already overloaded claims processing system. Alternatively, they may refuse to accept assignment on future claims. Importantly, they may be less willing to become participating physicians and suppliers. At this point, since physicians and suppliers have until April 30 to decide whether to participate in the program it is too early to quartify this effect. Moreover, since claims backlogs will be building up throughout the fiscal year, we expect that the most significant delays in claims payments and the adverse effects this will have on physician and supplier interest in participation will not be experienced until the end of FY 1986.

While all Part A providers will be affected by the delay in claims payment, those affected the most will be those whose claims are the most difficult for intermediaries to process; those without the sophistication to submit their claims electronically; and those who do not or cannot avail themselves of the periodic-interim-payment (PIP) method of payment. In addition, those providers who are already experiencing relatively slow payments, such as skilled nursing facilities and home health agencies may have particular difficulty coping with additional delays. Finally, the effects of a reduced cash flow will be greatest on smaller providers and/or those with high Medicare caseloads.

From the contractor's perspective, the major concern is that this policy both increases administrative costs and reduces the ability to handle unexpected jumps in claims volumes, new program changes, or temporary breakdowns in computer systems.

It is true that the slowing of claims payment will save interest on the Trust Funds, albeit at a cost to beneficiaries and providers. The Congress may support this idea as part of its federal deficit reduction efforts. If so, a revised claims payment policy should be enunciated and kept separate from contractors' continuing efforts to maximize the efficiency of claims processing. It is our view, however, that specific program changes rather than delays in claims payment would be a more appropriate approach to deficit reduction.

The FY 1987 Budget

We believe that the Administration's FY 1987 budget request of $957 million plus a $50 million contingency fund is inadequate to meet the needs of the program. The amount requested for expected workloads is $6.7 million less than Congress considered adequate for the current year in the FY 1986 appropriation legislation yet claims volumes will increase by 9-10 percent and inflation will increase contractor input costs. We are recommending to the Appropriations Committee that the Administration's request be increased by $140 million. At this funding level contractors should be able to return the responsiveness of Medicare claims processing to FY 1984 levels while achieving substantial paybacks in benefit dollars saved.

Complicating the FY 1987 situation is the uncertainty about the automatic budget cuts required by the Gramm-Rudman-Hollings legislation. As we indicated in previous testimony before this Subcommittee, Medicare administrative funding is not covered by the special rule limiting Medicare program cuts to 2% in FY 1987 and later years. Should automatic cuts in domestic programs on the order of 20% for FY 1987 be triggered by the Gramm-Rudman-Hollings process, the Medicare administrative system will experience massive disruption on a scale never before seen since the program began. Medicare contractor funding would be cut by about $200 million bringing it back to FY 1984 levels. Since FY 1984, however, claims volumes have grown by 104 million, inflation has increased 12.4%, and the program has become more complex as a result of legislative and other changes. Assuming current payback ratios, a cut of this magnitude would cost the Medicare program $1.8 billion. Actual costs would be much higher as contractors reduced claims screening activities to live within the reduced budget. Additionally, severe disruption would occur in claims processing, response to inquiries, and the implementation of many of the provisions included in the recent reconciliation legislation.

Competitive Bidding

We agree with the GAO that a major change from negotiated cost-reimbursement contracting to competitive, fixed-price contracting is neither justified by the record nor wise in term of cost-effective Medicare administration. As GAO notes, only 3 of the 7 competitive fixed price contracts have resulted in administrative savings and such savings must be balanced against the increases in benefit payments that often result when a new contractor is put in place. We also agree that regular use of competitive contracting in Medicare (whether fixed-price or cost-based) would unnecessarily risk disruption of services.

We strongly support efforts to identify through appropriate objective measures those Medicare contractors that cannot sustain an adequate level of performance and to replace them. It is our view that HCFA has had, even prior to the enactment of DEFRA in 1984, adequate statutory and contractual authority to exercise this important management function. For this reason we disagree with GAO's recommendation to extend the DEFRA authority to replace a fixed number of poorly performing contractors through a competitive bid procurement process. We recognize, however, that the Congress may wish to extend this authority temporarily to enable it to better assess the advantages and disadvantages of such authority to the program and its beneficiaries. Since the DEFRA authority was not used by HCFA until very recently, there may be inadequate information on which to make definitive judgments at this point. If the Subcommittee considers such a move, we would like to suggest later in this testimony a specific change to improve the process for identifying contractors to be replaced under the DEFRA authority.

The Use of "Cost-Caps"

In the Deficit Reduction Act of 1984, Congress amended the Medicare law to require the Secretary in determining reimbursement due a contractor to "take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated agency or organization."

The concept of setting criteria for determining the reasonableness of contractor claims processing budgets is appropriate; our disagreement with HCFA's implementation of the DEFRA authority is twofold. First, it has set budget limits by formula without adjustment through negotiations to take into account individual contractor circumstances. Second, it has applied these limits to all contractors, not just those with high costs. The term "cost cap" is actually a misnomer. In practice, since each and every contractor including those with the lowest unit costs had its budget reduced, the implementation of DEFRA resulted in formula-based budget cuts, not reasonable ceilings.

We agree with the GAO that HCFA's implementation of contractor budget cuts is inconsistent with the statutory authority and congressional intent. We would also add that the lack of budget negotiations with individual contractors is inconsistent with current contractual requirements. It was our belief that when Congress enacted section 2326 of DEFRA, it intended that an appropriate measure of the costs of an efficiently and economically operated contractor be considered as one of many elements in HCFA's determination of the budget necessary for an individual contractor to meet expected workload and performance measures. For example, the Conference Report on DEFRA stated

> "The conferees want to urge that any cost cutting measures be implemented in a careful manner with the understanding that the processing of Medicare claims is an important function and that savings measures not undermine beneficiary services, professional relations, productivity investment or program safeguards.
>
> It is the Committee's intent that the rates paid to contractors take account of their individual circumstances. Thus such factors as the relative complexity of the claims to be reviewed, the prevailing wages in the area, the relative need for beneficiary services, and other circumstances that may legitimately vary from contractor to contractor should be taken into account in determining each contractor's reasonable operating costs."

Contractor Performance Evaluation

The GAO report also reviewed the process and standards used by HCFA to evaluate contractor performance, and we agree that the current system is an improvement over earlier efforts. This system is known as the Contractor Performance Evaluation Program or CPEP. Four problems remain, however.

First, there is a weak relationship between the setting/enforcing of performance standards and the availability of funds to support the expected level of performance. At the moment, for example, HCFA is telling the contractors that due to impact of the Gramm-Rudman-Hollings legislation, funding will be at a very low level for FY 1986, but that the CPEP performance standards will not be relaxed except to encourage a slowdown in claims processing. In fact, many of the standards are higher for FY 1986 than they were for FY 1985. We can understand a shortage of funds but cannot understand the government's apparent belief that all performance standards must be met, regardless of the funding level. (This problem also became serious in FY 1985. Approximately 20 percent of contractors "failed" CPEP in FY 1984; the comparable figure for FY 1985 will be approximately 70 percent. The FY 1985 failure rate for "non-critical tasks" is above 90 percent.)

Second, CPEP should but does not accurately reflect HCFA's real priorities. The clearest reflection of that has been in HCFA's promulgation of the formula for ranking all contractors for purposes of "section 2326", i.e., deciding which contractors fall in the lowest 20 percent based on cost and performance criteria. Such contractors could be replaced using the competitive bidding authority provided by section 2326 of the Deficit Reduction Act of 1984. Although HCFA has long stated that CPEP conveys the "workplan" for contractors and fairly establishes the standards against which contractors will be measured, CPEP results were reweighted and new standards were applied to determine the section 2326 ranking. In effect, two sets of performance standards exist. While CPEP sets the official standard of performance (and the different weights within CPEP reflect official priorities), the ranking formula used to implement section 2326, established after the fact, set a different and more important standard.

Third, and sometimes for reasons beyond HCFA's control, performance requirements are not established until after planning and budgeting for the year have been completed. While DEFRA required the Secretary to publish contractor performance standards and criteria for public comment prior to their implementation, they have not been published early enough to be considered during the budget process, which begins about 6 months prior to the start of a fiscal year. Moreover, the published criteria do not include the detailed standards against which contractor performance will be measured. These detailed standards are promulgated through program instructions that generally are issued after the fiscal year has begun. This situation makes it difficult if not impossible for contractors to estimate budget needs with any degree of precision.

Fourth, benefit savings payback ratios, which are a necessary measure at this time of the cost-effectiveness a contractor's efforts to control benefit payments, should be applied in a more flexible and balanced manner. Such measures are imperfect and do not take into account the cost avoidance activities of the contractor through provider and beneficiary education or the potential savings that may be available in a particular area based on cost and utilization patterns. Moreover, important elements of a contractor's activities, such as making accurate coverage determinations are not weighted as heavily in the evaluation system as payback measures.

Recommendations for Change

With these comments in mind, we would like to suggest for your consideration a number of changes to begin addressing these problems. We do not believe that any of these changes requires new legislation. Given the GAO report, the continuing interest of this Subcommittee, and a willingness on the part of the Administration to modify its current approach to contractor management, all the problems discussed above can be resolved.

1. The Administration should begin to request, and agree to use, adequate funding for claims processing as well as for explicit program safeguard activities. For FY 1987 we believe the necessary total figure should be $1.15 billion, with at least $822 million of that amount dedicated to claims processing and beneficiary and provider services. (These amounts would not be sufficient, however, if automatic Gramm-Rudman-Hollings cuts are triggered for FY 1987.)

2. Regarding the evaluation of contractor performance, the Administration should:

    a. re-examine the CPEP program to ensure that there is good balance among

        - effective safeguarding of program benefit dollars,

        - high quality of service to beneficiaries and providers, and

- o low administrative costs.

We are concerned that the third (low administrative costs) is being overvalued, at the expense of the first two.

b. develop better, more flexible measures of the effectiveness of audit, reimbursement, and MR/UR activities to better recognize local patterns of medical care and Medicare expenditures and to recognize the cost avoidance effects of contractor activities.

3. In setting annual budgets for contractors, the Administration should:

   a. establish and promulgate annual performance expectations prior to setting any contractor's budget.

   b. negotiate with each contractor an appropriate budget level, recognizing the contractor's local circumstances, performance and costs during the preceding year, and performance expectations for the next year.

4. If the Congress supports the Administration's view that the payment of Medicare claims should be slowed further, then that policy should be clearly and publicly articulated for all beneficiaries and providers to understand. Further, such a policy-if adopted-should be implemented without resorting to mandated backlogs of unprocessed claims which inevitably increase administrative costs through greater volumes of duplicate claims and inquiries, loss of maximum processing efficiencies and slowed eligibility, coverage and medical review determinations.

5. Our final recommendation is that the Congress reject the Administration's proposal for unlimited authority for competitively bid contracts. In the event the Congress extends the section 2326 DEFRA authority for a limited number of competitively bid contracts, we recommend that the Secretary be required to use the same set of standards and criteria to evaluate contractor performance as are used to determine which contractors should be replaced because of consistent performance problems.

Conclusion

We are pleased to be provided this opportunity to help identify some of the problems that the Medicare administrative system now faces and to suggest some ideas for improvement. We would be most pleased to work with this Subcommittee, the Appropriations Committee, HCFA, and the GAO on these and other recommendations.

I would be pleased to answer any questions.

Blue Cross
and
Blue Shield
Association

Medicare

676 North St. Clair Street
Chicago, Illinois 60611
312/440-6000

February 4, 1986

Mr. Terrence J. Davis
Assistant Manager
Human Resources Division
United States General Accounting Office B-1
1705 Equitable Building
6325 Security Boulevard
Baltimore, MD 21207

Dear Mr. Davis:

We have carefully reviewed the several chapters you shared with us of your draft report to the Congress, "Medicare Contracting: Existing Authority Can Provide For Effective Program Administration." We believe those chapters are essentially on target. In particular, we agree that:

- A major change from negotiated, cost-reimbursement contracting to competitive, fixed-price contracting is neither justified by the record nor wise in term of cost-effective Medicare administration.
- Regular use of competitive contracting in Medicare (whether fixed-price or cost-based) would unnecessarily risk disruption of services, slower benefit payments and higher payment error rates.
- HHS's current authority allows for effective program management, including the removal of poorly performing contractors.
- Medicare contractors' administrative costs, expressed as a percentage of benefit payments, have long been extremely low compared with similar costs for private insurers (1.3% of benefits, or less than one-third of comparable private insurers' costs), and are continuing to decline. It is most regrettable that continued pressure to reduce administrative costs even further is risking the loss of benefit dollars on a far greater scale than all the administrative expenditures put together.
- HHS' efforts to unilaterally cut administrative costs by imposing "cost caps" on all contractors are inconsistent with Congressional intent. (Further, the lack of negotiations is a violation of current contractual requirements.)
- HHS should return to a Medicare contractor budget development process that is based on negotiation and the recognition of individual contractor circumstances.

In view of the events of the last two years, and especially the last several months, your report is most timely. I am hopeful it will surface the critical administrative issues for constructive discussions among all concerned parties.

In the comments that follow, we suggest some additional perspectives or emphases, and a couple of different issues you may want to consider. (Attached are more detailed comments on the draft, referenced by page number.)

At various points throughout the report there are references to some of the Medicare changes in recent years. Implicitly, you recognize the administrative challenges inherent in those changes. We would recommend that you pull some of that together to better highlight the environment of this period. HCFA and the contractors together have, in fact, confronted an exceedingly difficult set of challenges. The Administration and the Congress have not always given adequate consideration to the administrative costs and consequences of mandating so many programmatic changes in such a short period of time. To exacerbate that, Administration budget officials have kept the financial squeeze on HCFA.

Nonetheless, despite all the problems identified in your report, many of which are risking real injury to the program, a great deal has been accomplished over this period. For example, you may want to note:

- the new Prospective Payment System for hospitals, along with hospital training and the many necessary changes in hospital cost-reporting forms
- Medicare as secondary payer (where other insurance is the primary payer), especially for the working aged
- new benefits such as hospice, comprehenseive outpatient rehabilitation centers, and rural health clinics
- the physician payment freeze and the new participating physician concept, including physician directories and educational materials for physicians and beneficiaries
- clinical laboratory fee screens
- a completely new Uniform Bill used by providers for Medicare and other payers
- a new medical coding system for Part B services (HCPCS)
- claim and bill workload volumes that exceeded projections by 17 million claims in 1985
- EDP systems developments to support and encourage "paperless processing"
- toll-free telephone lines for participating physicians and beneficiaries

- expanded program safeguards activities of utilization review and provider audit
- overall reductions in average unit costs, and in the range of unit costs, of processing

On the one hand, therefore, we believe HCFA and the contractors can be proud of their record of accomplishment. On the other hand, the problems identified in your report are quite serious and must be corrected. They have significantly raised the risk of administrative failure. Parenthetically, we have serious reservations about what the record would have shown if HCFA had not had cost-reimbursement contracts. Your draft report acknowledges that a basic advantage to cost-reimbursement contracting is its flexibility to deal with change -- and change is a dominant characteristic of Medicare. The government should retain the proven mechanism of cost-reimbursement contracting. It works.

Perhaps the most fundamental problem in this arena is that Medicare administration is frequently viewed (by various levels of budget officials and sometimes by Congressional staff) as somehow independent of Medicare benefits. In our private business, we and most of our major accounts have learned to focus on the total cost of benefits plus administration; and to remember that one cannot change any part of that picture without affecting all the others. In fact, as cost concerns have escalated, we have all learned that relatively small investments in administration can have relatively large savings effects in benefit payments. Clearly, the government has also learned that, but important parts of the government apparently forget it, from time to time. The resulting fluctuations in administrative funding, compounded by frequent delays in the annual appropriations process, have incurred the kinds of benefit payment and service deterioration costs identified in your report. We would like to join with you, the Congress and the Administration in looking for ways to improve the total funding process regarding Medicare, such that this basic problem can be resolved.

Another issue related to the funding process is the government's expectations for contractor performance and how they are established, maintained, measured, and funded. HCFA's present Contractor Performance Evaluation Program (CPEP), while still evolving, is a major improvement over earlier efforts. HCFA has involved the contractors in developing and refining the performance measures and has been generally responsive to contractors' concerns. Three basic problems do remain, however, and we would urge your review of them.

First, there is a weak relationship between the setting/enforcing of performance standards and the availability of funds to support the performance. At the present moment, for example, HCFA is telling the contractors that due to impact of the Gramm-Rudman bill, funding will be at a very low level for FY86, but that the CPEP performance standards will not be relaxed. In fact, many of the standards are higher for FY86 than they were for FY85. The contractors can readily understand a shortage of funds but cannot understand the government's apparent belief that all performance standards must be met, regardless of the funding level. (This problem also became serious in FY1985. Note that approximately 20% of contractors "failed" CPEP in FY84; the comparable figure for FY85 will be approximately 80%! And the FY85 failure rate for "non-critical tasks" is above 90%!)

Second, CPEP should, but does not, accurately reflect the real priorities of HCFA's program. The clearest reflection of that has been in HCFA's promulgation of the formula for ranking all contractors for purposes of "2326 (a)," i.e., deciding which contractors fall in the lowest twenty percent based on cost and performance criteria. Although HCFA has long stated that CPEP conveys the "workplan" for contractors and fairly establishes the standards against which contractors will be measured, CPEP results were dramatically distorted by the 2326 formula. In effect, HCFA has said, "CPEP sets the official standard of performance (and the different weights within CPEP reflect official priorities), but now, after the fact, we will tell you what was really important."

Third, and sometimes for reasons beyond HCFA's control, performance requirements are not established until after planning and budgeting for the year have been completed. HCFA has not always been willing to recognize the dilemmas this causes contractors.

The one recommendation in your report with which we would argue is the one endorsing a continuation of the present HHS authority to use competitive fixed-price contracting on a limited basis (2326 (a)). We do agree that the threat of losing the business is an important incentive, and we agree that poorly performing contractors must be removed from the program, but new authority for competitive fixed-price bidding is neither necessary nor wise. HCFA already has ample authority to end the contractual relationship with a poor performer. But stimulating competitive replacements of intermediaries/carriers, in our view, establishes competitive dynamics at the wrong level, and risks further separation of administration from benefit payments. While firmly believing that competition at this level is not constructive, we enthusiastically support the Administration's position that promoting more price competition among delivery systems will benefit Medicare; and we endorse a variety of approaches to that end.

Parenthetically, we do agree with your conclusion that additional government staff would be necessary to manage competitive, fixed-price contracting, but the draft report implies that adding more government staff would make such contracting a good idea. We believe that the evidence does not support that conclusion.

From the beneficiaries' and providers' perspective, as well as our own, we would also invite GAO and the Congress to look further at the impact of "regionalization by specialization" of contractor functions. It is already possible for an individual beneficiary to have to deal with as many as nine different contractors for a single episode of illness (see specific comments below, page 12 of the attachment). In addition to the bureaucratic confusion and likely anger this will cause beneficiaries, such fragmentation of the contractors' functions makes it increasingly difficult to manage benefit utilization/expenditures in any well coordinated fashion.

Another concern many contractors have, which you might like to explore, is the structural organization of HCFA itself. It appears to us to be at least one cause of very poor and often inconsistent communications between the government and the contractors. Under HCFA's current structure, the whole Medicare program comes together only at the level of the HCFA Administrator -- but we don't deal with HCFA at that level. HCFA's two principal advisory bodies (the Fiscal Intermediary Group and the Carrier Representative Group) used to work with officials in whose hands the entire program rested; and, frankly, we found it easier then to resolve the problems that inevitably arise in administering this very complex program. Now we deal with and are bombarded by communications from several different components, both regionally and centrally. The aggregate result is more often heat than light.

The attached commentary is directed to specific points raised in your report. For any items needing clarification or further development, please do not hesitate to call.

Sincerely,

Harry P. Cain, II
Administrator
Federal Programs Division

February 4, 1986

BLUE CROSS BLUE SHIELD ASSOCIATION COMMENTS ON GENERAL ACCOUNTING OFFICE DRAFT REPORT

CHAPTER 1

INTRODUCTION

REFERENCE: Page 3, Paragraph 1 and Footnote 1

REPORT LANGUAGE:

[1]Under Medicare providers are defined as hospitals, skilled nursing facilities, home health agencies, hospices, comprehensive outpatient rehabilitation agencies, renal dialysis facilities, and ambulatory surgery centers.

BCBSA COMMENTS:

Renal dialysis facilities and ambulatory surgical centers are not providers under the definitions provided in the Medicare regulations (42 CFR 400.202).

REPORT REFERENCE: Page 3, Paragraph 1

REPORT LANGUAGE:

Currently, Medicare has intermediary contracts with six commercial insurance companies and the Blue Cross Association which in turn subcontracts with 45 local Blue Cross plans.

BCBSA COMMENTS:

The correct reference to the Blue Cross and Blue Shield organization is Blue Cross and Blue Shield Association, not Blue Cross Association. As of October 1, 1985, Blue Cross and Blue Shield Association subcontracts with 46 local Blue Cross Plans for Part A of Medicare. HCFA contracts directly with two Blue Cross Plans on an experimental, competitive fixed-price basis.

REPORT REFERENCE: Page 3, Paragraph 2

REPORT LANGUAGE:

Currently, Medicare has carrier contracts with 10 commercial insurance companies and 29 Blue Shield plans.

BCBSA COMMENTS:

As of October 1, 1985, HCFA contracts with 24 Blue Shield Plans on a cost-reimbursement basis and 3 Blue Shield Plans on an experimental, competitive fixed-price basis.

REPORT REFERENCE: Page 8, Paragraph 1

REPORT LANGUAGE:

Section 2326 of DEFRA authorized HHS to award two part A and two part B contracts on a competitively bid basis during each of fiscal years 1985 and 1986.

BCBSA COMMENTS:

DEFRA section 2326(a) provides this limited competitive bidding authority only for replacing cost-reimbursement contractors whose performance over time has been in the lowest 20th percentile of cost-reimbursement contractors. The statement in the draft report should reflect this important qualification.

REPORT REFERENCE: Page 8, Paragraph 1

REPORT LANGUAGE:

HCFA has not awarded any contracts under this authority.

BCBSA COMMENTS:

As noted in our preceding comments, HCFA must determine which cost-reimbursement contractors' performance has been in the lowest 20th percentile before determining which contractor territories can be competitively bid. This has not been an easy task for HCFA. It requires determining a performance-measuring system and then arraying the measured contractor performance to determine 20th percentile. HCFA has recently shared with the cost-reimbursement contractors its proposed methodology for determining a contractor's overall performance rating for the fiscal years 1983, 1984, and 1985. The contractors have expressed numerous concerns to HCFA about the proposed methodology, and HCFA has accepted some of the contractors' suggestions. The most serious of the remaining concerns is that HCFA has apparently changed the "rules of the game." Although HCFA has been telling contractors for years that the Contractor Performance Evaluation Program (CPEP) is the official measure of performance, HCFA's proposed methodology now lifts certain elements or categories from CPEP for special emphasis, over and above that originally applied and known to the contractors. After years of telling contractors that CPEP is the measure of their performance, HCFA is now changing the measure of that performance on a retroactive basis. We have attached a copy of our comments to HCFA about the proposed selection methodology. (Please see Exhibit A.)

CHAPTER 2
CHANGE TO COMPETITIVE FIXED-PRICE CONTRACTING IN THE MEDICARE PROGRAM IS NOT JUSTIFIED

REPORT REFERENCE: Page 14, Paragraph 1

REPORT LANGUAGE:

We continue to question whether Medicare should make general use of competitive contracting for several reasons. First, the frequent use of competition could increase Medicare administrative problems, including the risk of poor contractor performance....Second, administering competitive fixed-price contracts generally consumes more of HCFA's management resources and sufficient resourses may not be available for multiple competitions.

BCBSA COMMENTS:

We support your conclusion that Medicare should not make general use of competitive contracting, and we agree with the reasons listed. We would add, however, that the basic advantage of the present cost-reimbursement contracting is its inherent flexibility to respond to program changes quickly, with minimal disruption.

While we agree that HCFA's resources are strained in administering competitive fixed-price contracts, we believe that increasing these resources is not the answer. The report implies that if HCFA had more resources, competitive contracting would be preferable to the present contracting method. We do not believe this is the case. The basic problem remains. Competitive fixed-price contracting does not assure the flexibility needed to administer an ever-changing program such as Medicare. Competitive fixed-price contracting lends itself best to a program or product where performance or delivery specifications are known in advance and are subject to few changes. These conditions do not exist in the Medicare program, and probably never will. Additionally, providing HCFA more resources to manage a different contract form is a questionable use of scarce resources.

REFERENCE: Page 14, Paragraph 2

REPORT LANGUAGE:

...there may be little need for such a mechanism in Medicare because:... DEFRA gave HCFA additional authority to control payments to cost contractors by permitting HCFA to disallow costs that exceed a standard for efficiency.

BCBSA COMMENTS:

To our knowledge HCFA has not developed or published the DEFRA-required standard for efficiency. Clearly, that development is necessary. The contractors stand ready to assist HCFA in its development. (See our comment below, reference: page 23, Paragraph 3.)

REFERENCE: Page 15, Paragraph 2

REPORT LANGUAGE:

The ability to use competitive fixed-price contracting, as part of a coordinated management strategy, would give HCFA added flexibility and leverage in dealing with the contractor community and in removing poor performers from the Medicare program.

BCBSA COMMENTS:

Competitive fixed-price contracting authority is not necessary. HCFA has experimental authority, which we support, and HCFA now employs competitive, fixed-price contracting under this experimental authority. "Added flexibility and leverage" is not necessary. What is necessary is the development and publication of a management plan, coupled with objective contractor performance standards, and removal of those contractors where performance does not meet the required performance standards.

REFERENCE: Page 15, Paragraph 3

REPORT LANGUAGE:

As was the case in the two Illinois experiments,...

BCBSA COMMENTS:

Here and at several subsequent places in this chapter, the report tends to lump together the two Illinois experiments. While we agree with the general conclusions of the chapter, we strenuously object to the suggested equation between "Illinois I" and "Illinois II." Attached to these comments is a letter from the Illinois Plan which addresses this point in some detail. (Please see Exhibit B.)

REFERENCE: Page 20, Paragraph 3

REPORT LANGUAGE:

Another lesson learned from [the fixed-price experiments] was that any problems that arise during the initial operation phase can have a compounding effect (for example, as backlogs grow, so do inquiries from providers and beneficiaries which in turn increase workload and can result in further backlogs).

BCBSA COMMENTS:

We agree with this illustration about claims backlogs. Further, the illustration applies to all contractors, not just those with competitively bid, fixed-price contracts. Please also see our comments about claims processing volumes and backlogs in our remarks on draft chapter IV.

REFERENCE: PAGE 21, PARAGRAPH 1

REPORT LANGUAGE:

HCFA's lessons learned illustrate that the administration of competitively awarded contracts have generally required more HCFA resources than the traditional cost-type contracts during the transition and early operational phases of the contract cycle....They added that there is very little difference in resource requirements for cost contract and competitive fixed-price contracts after the contracts are fully operational.

BCBSA COMMENTS:

We agree with the first sentence, but not the second. Without exception, the fixed-price contractors have complained about the "red tape" and inordinate time delays in HCFA's processing the price changes for change orders. HCFA apparently expects these contractors to do the extra work required by the change order and fund the work from their own resources pending HCFA's decision. Even after HCFA officials have agreed to the price change, it is not uncommon for three or more months to pass before HCFA actually makes the money available to the contractors.

REFERENCE: Page 21, Paragraph 3

REPORT LANGUAGE:

In the competitive fixed-price experiments to date, HCFA has been able to borrow staff from other functions in its efforts to manage these contracts. But HCFA's staffing has been declining over the past few years, and HCFA officials told us that they do not have sufficient staff to manage Medicare contracting under a total competitive environment.

BCBSA COMMENTS:

Based on our discussions with Blue Cross and Blue Shield Plans with fixed-price experiments, we do not believe HCFA's staffing, borrowed or otherwise, has been sufficient to deal with necessary price changes in a timely manner. Therefore, we are not suprised that HCFA believes it does not have sufficient staff to manage Medicare contracting under a totally competitive fixed-price contracting environment. The most pressing need for staff would likely be in the HCFA Regional Offices where routine monitoring and close communications with the contractors are necessary.

Regardless, the addition of more HCFA staff is not a panacea. In our view, it would be unwise to divert already scarce resources to support an increased number of competitively bid, fixed-price contracting arrangements. If, however, HCFA does gain additional authority to broaden competitive fixed-price contracting, it is essential that HCFA have enough staff to process the funding for necessary change orders in a prompt manner.

REFERENCE: Page 22, Table 2.1

REPORT LANGUAGE:

Table 2.1: Medicare Claims Volume and Processing Costs for Fiscal Years 1980 and 1984. [Chart]

BCBSA COMMENTS:

This chart compares Medicare Part A and Medicare Part B volumes and unit costs. We believe the presentation is misleading. Part A unit costs are not really comparable to the Part B unit costs. Part A operations include provider audit and reimbursement costs which are not directly related to claims processing costs. We believe this chart and the subsequent analysis, which removes the effects of inflation, would be more meaningful if only claims processing costs were included for Part A. We recognize that it may not be possible to isolate Part A claims processing costs before 1983 because of different reporting methods used then. At a minimum, the Part A costs should not include audit and reimbursement costs in any side-by-side display with Part B costs.

REFERENCE: Page 23, Paragraph 2

REPORT LANGUAGE

These figures show that HCFA has been successful in constraining Medicare's administrative costs and has done so primarily through controls over the cost contracts.

BCBSA COMMENTS:

We agree that Medicare's administrative costs have been constrained, but we believe the draft report should recognize contractor efforts, as well as HCFA's, to constrain costs. Until quite recently, HCFA has approved funding for contractors who could demonstrate economies from contractor-initiated productivity investments. As an example, it was the contractors, not HCFA, that originated electronic media claims (EMC) processing. In our opinion, the draft report's statement that "...it does not appear that, on an overall basis, Medicare's contract costs are unreasonably high" is an understatement. The report would be more accurate if the statement were made on a positive basis. We suggest the sentence acknowlege that Medicare administrative costs are, in fact, very low.

REFERENCE: Page 23, Paragraph 3

REPORT LANGUAGE:

In effect, HCFA can now disallow contractor costs that exceed a standard for efficiency, and thereby prevent cost contractors from receiving unreasonable payments.

BCBSA COMMENTS:

The DEFRA legislation which provided HCFA this expanded authority assumes that HCFA would make a determination of "...the costs which must be incurred by an efficiently and economically operated" contractor. Setting such a standard is critical for the implementation of the DEFRA authority. To our knowledge, HCFA has neither determined the required standard nor requested funding on the basis of such standard. Rather, HCFA has used this authority in DEFRA to justify reductions of all contractors' budgets.

REFERENCE: Page 25, Paragraph 4

REPORT LANGUAGE:

We estimated differences in cost between the cost and fixed-price contracts using a regression model and data from 1970 to 1984.

BCBSA COMMENTS:

We agree that the GAO methodology is a better estimation of cost differences than the HCFA revised methodology, but we have a question about both methodologies. Do both include all price changes for fixed-price contractors, including those pending or under appeal? We understand there are millions of dollars of price-change requests still pending and some of the fixed price contractors are considering appealing HCFA's decision on others. Any comparison of costs by contract type must recognize all price changes.

REFERENCE: Page 25, Paragraph 1

REPORT LANGUAGE:

In addition to any administrative cost savings resulting directly from competition, the authority to use competition has indirectly helped HCFA in its efforts to reduce the cost of all contractors. HCFA officials stated that this authority has provided them with additional leverage in negotiating with the cost contractors. Some contractors agreed, pointing out that the threat of losing their territories through competition has stimulated them to improve their performance and their administrative costs. (Emphasis added)

BCBSA COMMENTS:

We believe this paragraph misinterprets a fundamental point and may reflect a misunderstanding. We strongly believe that the threat of competition has not been responsible for reducing the costs of all contractors. The cost reduction is a result of contractors and HCFA working together to achieve economies. Where additional leverage has been used, that leverage relates to the threat of removing the contract entirely, not the threat of putting the contract up for competitive bidding.

REFERENCE: Page 28, Paragraph 4 (continued on the top of Page 29)

REPORT LANGUAGE:

As we discussed extensively in our 1979 report on Medicare contracting, there is a large potential to achieve administrative cost savings through consolidation of contractor areas. This savings results because, depending on the extent of workload added to a contractor, its fixed costs remain constant and only its variable costs increase. This concept is known as incremental cost....

BCBSA COMMENTS:

We recognize potential economies can be achieved through consolidation of contractor areas. Indeed, among Blue Cross Plans, such cost-effective consolidations have occurred. However, the consolidations have almost invariably presented problems of access for providers and beneficiaries in the areas no longer directly served because of the consolidation. We believe the beneficial effects of consolidation need to be balanced carefully against the loss of the local contractor's influence on the administration and interpretation of medical practice patterns and the loss of provider and beneficiary access.

We support the concept of incremental costing, when it applies. For example, where an existing contractor assumes the workload of another contractor, the incremental costing concept is valid only where the surviving contractor's data processing system will process the additional workload without major changes. In other words, there is a limit to the application of incremental costs for Medicare contractors, and that limit is directly related to the size of the increase in claims volume. Where the surviving contractor must acquire an entirely new claims processing system to handle the total volume, incremental costing will have limited value.

Any concept of incremental costing must use agreed-upon and understood concepts. HCFA's present approach to incremental costing (processing at

75% of the previous unit cost) is a mystery to most contractors. Please also see our comments on draft Chapter IV.

REFERENCE: Page 30, Paragraph 2

REPORT LANGUAGE:

The administrative cost savings from competitive contracting stems from several factors, chiefly:...--eliminating or modifying certain contractor functions,...

BCBSA COMMENTS:

We are not aware of any competitive contracts which have eliminated or modified contractor functions. To our knowledge, the competitive contractors have assumed all of the functions of the previous contractors.

REFERENCE: Page 31, Paragraph 21

REPORT LANGUAGE:

...there has been a general decrease in the number of offerors for competitive contracts....In response to the general decline in competition, several Medicare contractors offered the following:

> --Contractors believe that HCFA's long-term strategy is to consolidate territories to the point where there will only be several large regional contractors in the country.
>
> --Contractors are concerned that the larger contractors are determined to win competitive procurements by offering prices below actual costs, hoping that they will later be able to retain the contract at a profitable level.

BCBSA COMMENTS:

In addition to these reasons, we believe there is another reason for the decline in competition, namely, the difficulties contractors have experienced in receiving money for change orders. As we have indicated earlier in these comments, the fixed-price contractors unanimously have complained about having to implement changes without prompt and corresponding action by HCFA on the contract price changes. Indeed, recent experience indicates HCFA's action may invite litigation because of lack of available funding. Even with the time delay in granting the price change or, in many cases, HCFA's arbitrary reductions in contractor cost estimates to implement the change, HCFA requires the contractor to implement the change and use private funds in the interim.

REFERENCE: Page 32, Paragraph 4

REPORT LANGUAGE:

Since our earlier reports HCFA has taken a number of actions in line with our recommendations and has achieved program improvements under the cost-type contracts. For example, since 1980, HCFA has consolidated the areas of several Medicare contractors; primarily to achieve program efficiencies and administrative cost savings. Consolidations can also be used to eliminate poor performers but generally have not been used for this purpose.

BCBSA COMMENTS:

We believe it is important for beneficiaries and providers to have easy access to Medicare contractors. Further consolidation of contractors may work against this objective. The importance of this local beneficiary and provider contact should be an important element in any evaluation for future consolidations. In short, the consolidations that have already occurred may be enough. Contractors with a strong local presence are in the best position to understand the unique characteristics of medical care and financing in their areas. Established relationships with the provider community and an identification with the local beneficiary community are important for program understanding and acceptance by these groups, particularly when implementing new program requirements.

A few years ago, HCFA indicated a desire to have state-wide intermediaries and carriers. This is generally the case at present. We are not aware of HCFA's plans for further consolidation. Consolidations often present the same problem as changing contractors and generally should be avoided in the absence of performance problems.

REFERENCE: Page 34, Paragraph 1

REPORT LANGUAGE:

HCFA has taken other actions aimed at improving the program, including:...

--Consolidating certain functions for greater control and productivity. For example, two regional carriers have been assigned responsibilities for processing all claims related to nutritional therapy, and by law, home health agency claims will be processed by 10 regional intermediaries. HCFA told us that it is reviewing its operations for further specialization actions.

BCBSA COMMENTS:

We have long maintained that regionalization by type of claim is not necessary. It may also be counterproductive and expensive, especially where provider cost settlements require field units. Rather than regionalization, what is needed is clear and consistent HCFA policy about processing claims, by individual type of claim.

Specialization and fragmentation of the traditional contractor functions can have a negative effect on the beneficiaries' and providers' understanding of Medicare. It is particularly confusing to the beneficiary to have to deal with multiple contractors. It is now possible for a beneficiary to have to deal with as many as eight different contractors for a single episode of illness (hospital inpatient, medical, SNF, HHA, nutrition, CORF, hospice, and rural health clinic). If there were any inpatient denials by the PRO, the number would rise to nine, and in the worst possible case (a beneficiary suffering a relapse while on travel in another part of the country), the number could go to fifteen! And now we understand HCFA is considering two more new types of specialized contractors: for durable medical equipment and for certain laboratory services. It is an additional burden -- in an already complicated program -- for providers to submit claims to multiple contractors, and it may influence them to accept assignment on fewer bills.

We also oppose further contractor specialization because it will harm any one contractor's ability to track the range of services provided an individual beneficiary and perform appropriate utilization review. Tracking all of a beneficiary's medical services is basic to the concept of "Benefits Management," one of the most promising trends in health care financing. The "patient profile," which is used by many contractors to gather as complete a picture as possible of a beneficiary's medical claims, will be of limited use if the contractor no longer processes the multiple claim types for a given beneficiary. Further specialization and fragmentation of contractor functions is directly contrary to the Benefits Management approach, which HCFA is actively encouraging to improve the stewardship of Medicare Trust Fund dollars.

REFERENCE: Page 34, Paragraph 2

REPORT LANGUAGE:

HCFA stated that "this multiplicity of approaches permits the evolutionary development of the program in continuing partnership with the contracting community, while avoiding major disruptions."

BCBSA COMMENTS:

We support the concept of "a continuing partnership with the contracting community." We do not believe further regionalization will promote such a partnership and, in fact, may work against it.

REFERENCE: Page 35, Paragraph 1

REPORT LANGUAGE:

They [HCFA officials] said competitive contracting provided them with a vehicle to motivate contractors to meet performance and price requirements.

BCBSA COMMENTS:

The threat of competitive contracting is not necessarily a motivation for improving performance. It is the threat of loss of the contract that is a motivation. This threat has always been available to HCFA. Further authority for competitive bidding is not necessary for contractor motivation.

REFERENCE: Page 37, Paragraph 3

REPORT LANGUAGE:

We believe that limited authority to competitively award contracts, similar to the authority provided in DEFRA, could be a useful tool for HCFA to use when removing poor performing contractors from the Medicare program.

BCBSA COMMENTS:

We disagree with this recommendation. HCFA does not need competitive contracting authority to remove poor performers. The draft report clearly concludes that the regular use of competition is not in the best interest of the Medicare program. This being the conclusion of the study, we question the logic that would recommend limited authority to use a procedure that is not in the best interest of the program.

Additionally, the trouble with the authority now available (2326(a)) is revealed by the current DHHS opinion that even though cost and performance objectives are now being reached without using the authority, the department must use the authority - and run the risks entailed - or the Congress will not grant HCFA its future requests for other authorities. That is, one can argue, as your report does, that this authority is useful as a threat - but unfortunately the authority is likely to be used - for good reasons or bad - and thus run serious, unnecessary risks.

CHAPTER 4

HCFA'S MANAGEMENT OF COST CONTRACTORS -- RECENT BUDGETARY ACTIONS ADVERSELY AFFECTING PROGRAM PAYMENTS AND SERVICES

REFERENCE: Page 44, Paragraph 2

REPORT LANGUAGE:

To account for the remaining $49.2 million in excess costs above the appropriated funds [for FY85], HCFA reallocated money among the contractor budget categories, with the biggest change being a $35.7 million decrease in the funds allocated to claims processing. HHS did not seek a supplemental appropriation for contractor funding in fiscal year 1985.

BCBSA COMMENTS:

This accurate description about the adequacy of the FY85 appropriations highlights two problems. First, despite HCFA's own recognition that the appropriated funds were inadequate, there was no request for a supplemental appropriation - even in light of the DEFRA-required new activities.

Second, the government has arbitrarily and inaccurately classified contractor budgets into the three activities of claims processing, program safeguards, and productivity investments. It may be convenient to label contractor activities by these three categories, but in the actual operating environments those categories are not mutually exclusive. In practice, contractor activities cannot be easily segregated by such convenient lables because each of these three is an integral component of the other two. Taking money from one category (or increasing it, for that matter) will affect the other two categories.

HCFA has refused to allow a contractor the flexibility to manage within the total budget funds available to that contractor. Contractors have extremely limited authority to manage to the "bottom-line." HCFA requires contractors to manage within the three artificial categories noted above and, in some cases, even more finite breakdowns.

Decreasing the money available for claims processing activities (as a result of the reallocation of total appropriated funds) has a negative effect on benefit-dollar payout. Where forced to economize in claims processing, contractors must find ways to reduce labor costs. Automated screens and edits that "kick out" claims for manual handling - and often for benefit savings - become "too expensive." Contractors economize. and the programs loses money.

REFERENCE: Page 45, 46 and Paragraphs 1-4 on Page 47

REPORT LANGUAGE:

HCFA ARBITRARILY CUT CONTRACTORS' BUDGETS

BCBSA RESPONSE:

We agree with the draft report's description of the FY85 budget process and believe that process produced at least three effects:

1. HCFA's threat to terminate the contract of a contractor that failed to meet its cost cap motivated contractors to try to work within the cost cap. The loss-of-contract threat may also have influenced some contractors to report less than their total costs (as noted further in the draft on pages 51 and 52).

2. During FY 85 HCFA did not abide by the financial provisions of the cost-reimbursement contracts. These provisions require the contractor to notify HCFA of a projected budget overrun and, at the same time, provide HCFA suggestions of activities which can be abated in order to reduce the budget overrun. HCFA must then make a decision to increase the budget, agree to abatement of activities, or some combination of those two alternatives. In FY85, HCFA "persuaded" some contractors to withdraw abatements they had submitted in accord with their contracts.

3. The relationship between HCFA and the contractors was increasingly strained. The "partnership" became more of a fiction.

REFERENCE: Page 47, Paragraph 5

REPORT LANGUAGE:

We do not believe that the formula HCFA used to reduce claims processing costs adequately considers individual contractor circumstances.

BCBSA COMMENTS:

We agree with this statement and submit that it applies to situations other than the budget, as well. HCFA's goals for EMC and other program operations often ignore different operating environments and are done with little or no consultation with the contractors.

REFERENCE: Page 47, Paragraph 5 (continued on page 48)

REPORT LANGUAGE:

... in establishing the cost per claim caps for contractors, HCFA assumed that each contractor could and would process the workload increase between 1984 and 1985 at 75 percent of that contractor's base unit cost for 1984. This assumption requires the same level of productivity among all contractors.

BCBSA COMMENTS:

We accept the concept of incremental costs (with the reservation noted earlier), but maintain that incremental costs will differ by contractor because of operating systems and types of claim, as well as the other factors mentioned in the draft report. The contractors have repeatedly asked HCFA for an explanation of its apparently arbitrary 75% incremental-cost figure. The contractors have received no explanation, and HCFA is continuing to use this same 75% incremental-cost approach for FY86.

REFERENCE: Page 48, Paragraph 2

REPORT LANGUAGE:

The [HCFA] task force recommended that budget officials take steps to provide more accurate forecasting of individual contractor workloads.

BCBSA COMMENTS:

We are pleased to learn that an internal HCFA task force is concerned about more accurate workload forecasts. Despite this hopeful sign, we note that there appear to be significant understatements in forecasting workloads again in FY86. For FY86, HCFA has recently issued instructions that contractors will process only the budgeted workload, regardless of the actual volume of claims received.

See also comments about the FY86 budget process.

REFERENCE: Page 49 through 52

REPORT LANGUAGE:

[Continued discussion] HCFA underprojected the fiscal year 1985 workload.

BCBSA COMMENTS:

We agree with the report's description of the problems in HCFA's workload projection and the examples used to illustrate the contractors' difficulty in securing funding to process the additional workload. The report notes that the contractor's final administrative cost proposals (FACPs) were not available at the time GAO completed its work. These figures should be available by the end of January 1986, and GAO may want to supplement its report when those figures are known. We would caution, however, that, as noted in the draft report, some contractors may have "elected" to report less than their true cost figures.

REFERENCE: Page 52 through 56

REPORT LANGUAGE:

FISCAL YEAR 1986 BUDGETARY SHORTFALL COULD BE MUCH GREATER THAN THAT IN 1985

BCBSA COMMENTS:

Our own projections for FY86 budget needs are in excess of $1 billion, and are therefore close to the GAO estimates presented in the draft report. Once again, it appears that HCFA will make up the deficit by imposing arbitrary cost caps and reducing funding available for claims processing. We understand HCFA also plans to cut the funds for program safeguards. As we have noted in our comments about the FY85 funding process, cutting claims processing funds is inappropriate. The claims must be processed in an accurate and timely manner as a fundamental obligation of the program. Cutting the claims processing funds will lead to a serious deterioration in service to beneficiaries and providers of medical services, supplies, and equipment. Cuts in program safeguard activities will mean the taxpayer can no longer be assured the government and its contractors are making every effort to pay for only appropriate levels of Medicare services.

Although the President has signed an appropriations bill which includes Medicare contractor funding at a level higher than the Administration requested, we understand that HCFA has not been allowed to make the legislated appropriations available to contractors. Whether for reasons of Gramm-Rudman or original intent, HCFA is still operating on the Administration's original request and is telling the contractors they must operate within these inadequate budgets. HCFA has instructed contractors that "...your rate of processing claims for FY86 will be based on the Budget Distribution approved by your servicing HCFA Regional Office....If your claims processed percentage as projected for the entire budget distribution period exceeds the Budget Distribution by more than 1 percent, the Regional Office will prescribe a course of action to bring your processed claims workload back in line with your budget."

The congressional report which accompanied the appropriations bill specifically directed that

> ...adequate resources be allocated to basic claims processing activities to ensure that the backlog of unprocessed claims be reduced to the maximum extent possible, and that under no circumstances should it be

> allowed to increase. Further, the conferees direct that services to beneficiaries not be allowed to deteriorate.

In contrast to this congressional direction, HCFA has told contractors that the days work on hand can build up to 20 days work on hand (compared to a Part A level of 7.9 days in 1985 and 5.9 days in 1984 and a Part B level of 9.4 days in 1985 and 8.2 in 1984). We understand some HCFA officials are projecting a backlog of 23 days work on hand for 1987.

Clearly HCFA is sitting on the horns of a dilemma. On the one hand, HCFA recognizes the need to process all the claims. On the other hand, HCFA recognizes there is not enough money to do that. What is missing in this situation, as it was in FY85, is any willingness by the government to work with its contractors to modify performance expectations to match the funding available. Contractors can readily understand a shortage of money; they cannot understand HCFA's apparent belief that all performance standards must be met, regardless of the funding available.

In the current budget situation, HCFA has limited the amount of funds contractors can draw. At least one contractor, faced with greater-than-budgeted workload, has had to encourage employees to take vacation time early or to take time off without pay because the contractor was not allowed to draw enough money to pay the salaries of all its Medicare staff.

Not processing the workload will undoubtedly lead to increased costs in the future. Claims backlogs won't just go away. They will have to be processed some day. HCFA recognized the difficulties in dealing with fixed-price contractors when claims backlogs began to build and acknowledged that those backlogs can have a "compounding effect" (see draft report page 20). Now HCFA is reluctant to recognize similar difficulties for the cost-reimbursement contractors.

REFERENCE: Page 65, Paragraph 2

REPORT LANGUAGE:

HCFA officials acknowledge that the slowdown in claims payment is due in part to "the intense administrative cost containment pressure" put on contractors. However, they justififed this action by stating that payments in the past have been "overly prompt," and a slowdown could save Medicare dollars through interest earned on invested Medicare Trust Fund money.

BCBSA COMMENTS:

We agree that a slowdown could produce greater interest earnings for the Medicare Trust Fund. Whether such slowdown is in the best interest of the Medicare program is an unanswered question. We believe it is not. We do not know the basis for the HCFA conclusion that past Medicare payments have been "overly prompt." Our experience in private business is comparable to Medicare, and in many cases our private payments are made more quickly than Medicare payments. (Certainly on the Part A side, when comparing private business and Medicare payment speed, it is important to measure the length of time from date-of-service as well as from the date-of-billing. Medicare requirements tend to cause long delays between the date-of-service and the date when the provider can submit an acceptable bill to the intermediary. Unnecessary delays in bill processing will only exacerbate the problem.)

Blue Cross
and
Blue Shield
Association

Medicare

676 North St. Clair Street
Chicago, Illinois 60611
312/440-6000

EXHIBIT A

October 10, 1985

Mr. John Berry, Director
Bureau of Program Operations
Health Care Financing Administration
Meadows East Building
6325 Security Boulevard
Baltimore, Maryland 21207

Dear John:

We appreciate the opportunity to comment on the 2326(a) criteria at this stage in their development. Given your tight schedule for implementing in FY86, there is little time to spare.

We are pleased to see that the Contractor Performance Evaluation Program (CPEP) rankings will be used as the primary measure of contractors' performance in HCFA's implementation of Section 2326(a) of the Deficit Reduction Act (DEFRA) of 1984. Although we have often been critical of CPEP and what we perceived to be the regional offices uneven application of CPEP throughout the nation, we believe that CPEP is the best available mechanism to uniformally measure a broad and complex program. We also agree with weighting the most recent years the heaviest in the proposed ranking or evaluation methodologies, although the appropriate value of the weights given to each particular fiscal year will depend heavily on the way in which FY85 data is ultimately handled, as noted below.

We are concerned that the use and value of CPEP could be seriously compromised by the proposed methodology, specifically, by pulling program safeguards and unit costs out of CPEP and magnifying their weights. We believe that CPEP alone, without duplication, and/or expansion should be the basis for implementing Section 2326 of DEFRA. CPEP was established as the basic device to measure contractor's performance. The performance measures, the performance levels, the performance weights, and the methods of evaluation in CPEP have all been developed in consultation with contractors and, in HCFA's own words, constitute a workplan for a given year. Contractors have known in advance what was expected of them. To change the performance expectation now by changing the weights of certain items creates an ex post facto rule, and serious inequity. Moreover, HCFA would be creating, retroactively, "super critical" tasks of such importance that they could, regardless of whether or not the tasks were passed in CPEP, result in a jeopardy situation.

Regarding the proposed weighting methodology, we do not believe the material you distributed for comment contained enough information to evaluate the total proposal. Although not available in the material, we understand that the proposed weights are applied to CPEP ranks (best to worst). CPEP scores were not used to rank those items emphasized separately from CPEP. Instead HCFA used rankings of actual payback ratios, overpayment error rates, and raw unit cost figures. Many of our comments above and some that follow are based on this understanding. The diverse bases for the rankings lead us to reemphasizing that CPEP alone should be used.

We are also quite concerned over use of partial FY85 data as suggested by HCFA in the proposed methodology. Partial data distorts criteria designed to measure performance on an annual basis. For example, fourth quarter costs change greatly from third quarter costs every fiscal year. Contractors follow a wide variety of paths to ensure that by year end they meet their targets. Therefore, third quarter figures are very unreliable indicators of fiscal year performance. Because more total claims are processed by year end and audit backlogs reduce greatly in the fourth quarter, third quarter measures are also unreliable for MR, MSP, audit payback ratios, settlement and overpayment error rates. We understand your scheduling problems and agree that you do not have the time to wait for the completed FY85 ACERS. However, rather than use partial data to measure recent performace with respect to payment safeguards and unit costs, we suggest that HCFA postpone using this data until total FY85 data is available. We understand the reports needed to compute actual payback ratios and unit costs will be available by mid-November.

Finally, HCFA's method of applying weights to a contractor's rank on a given performance measure distorts the range of performance among the contractor community and may result in faulty identification of those contractors who consistently appear in the lowest 20th percentile. For example, if there are 51 Part A contractors the poorest performer would receive 51 times as many points for that criterion as the contractor ranked number one. A more equitable approach involves the use of indexing. Under this proposal, if the best contractor's score for a given measure is 1000, and the worst contractor's score is 850, the indexing approach would rank the worst contractor at 1.15 or 15% lower than the best.

In summary, we believe that CPEP alone, weighted for emphasis on most recent performance, should be HCFA's criterion for implementing Section 2326(a). Further, full FY85 data should be used, at least for the critical items available by mid-November.

As you will understand, our comments might have been less disjointed had we had more time for careful review and analysis. Nonetheless, a short time is better than no opportunity at all. We do appreciate the opportunity. Attached are detailed comments specifically related to the performance criteria considered, the distribution of weights and the assumptions used to develop the methodologies. I hope you find these comments helpful. If you have any questions, please let me know.

Sincerely,

Harry

Harry P. Cain, II
Administrator
Federal Programs Administration

BLUE CROSS AND BLUE SHIELD ASSOCIATION COMMENTS
CONCERNING
RANKING METHODOLOGY TO IMPLEMENT
SECTION 2326(a) of the 1984 DEFICIT REDUCTION ACT (DEFRA)

We believe that actual CPEP scores, weighted for emphasis on most recent performance, serves HCFA's purpose of identifying those contractors who fall into the lowest 20th percentile over a period of time. Use of partial FY data is misleading. HCFA's ranking methodology distorts contractor performances. However, if HCFA is trying to make fine distinctions among those contractors in the lowest 20th percentile, through emphasis on particular performance indicators, we offer the following comments for your consideration.

Performance Criteria Considered

- Review of the performance data elements discloses that elements already in the official Part A CPEP program have been duplicated in the proposal. This would distort the balance already in the CPEP program and these duplications will skew any rankings.
- We do not believe the FY 1983 benefit savings to cost ratio (MR savings) is a valid performance criterion because:
  - (1) MR savings were not included in the FY83 CPEP. For HCFA to consider this ratio as a performance measure two years later does not seem equitable.
  - (2) Manual instructions requiring contractors to collect and report savings due to medical review activities were not issued until June, 1983.
  - (3) Early versions of the Report of Benefit Savings lacked clarity and therefore savings were not consistently reported by contractors.
  - (4) When manual instructions were issued, contractors were informed that the Report of Benefit Savings would not be used to measure individual contractor performance. Instead, HCFA should use the **report as a data base to demonstrate to Congress the effectiveness of Section 118 of TEFRA. Section 118 required HCFA to supplement Medicare contractor budgets for FY83, 84 and 85 by $45 million in each year to be spent specifically for contractor audit and medical review activities.**
  - (5) It is not clear how HCFA calculated ratios for FY83 since no formula was available to contractors at that time.
- FY82, 83 and 84 unit cost figures were calculated using regression formulas which HCFA has since acknowledged were faulty by dropping them.

We believe a significant problem exists with HCFA's use of unit cost as a performance criterion. Unit costs, as defined by HCFA, do not reflect the total administrative unit costs per contractor, but rather an arbitrary unit cost such as bill payment unit cost or bill processing unit cost. Comparisons of subset of total administative unit cost can be misleading because of reporting differences. Also these costs account for 2/10 of 1% of benefits paid and about 40% of total administrative costs. The weighted values of this one element are much too great.

HCFA initiated a new reporting format for administrative costs in FY84. The format was changed once again for Part B in FY85 to include costs for Physician Fee Freeze and MSP. To rank contractors by unit cost may not be consistent unless total unit cost is employed. If unit cost for lines one and three is used, the fiscal years will not be comparable.

Distribution of Weights

o Over the last few years HCFA has identified a number of CPEP elements as "critical", but, under this proposal some of those elements no longer seem important and others seem super critical. This amounts to applying standards retroactively. Also HCFA is devaluing by comparison the work by contractors who achieved the high scores in other "critical" tasks not separated in the methodology.

o The weights assigned to payment safeguards by the evaluation methodology are for periods in which contractors were under extreme pressure to reduce administrative costs, not to maximize program dollar payouts. HCFA has made it known that FY86 will be the last year that contractors will be under such pressure (administrative costs), and that beginning in FY86 the name of the game will be benefit dollar control. It seems strange then, that "program safeguards" would be so heavily weighted for periods in which they were not the main emphasis.

o HCFA's proposal is not clear as to whether actual MR ratios or CPEP scores will be used for 84 and 85. If it is CPEP score, then a contractor with an acceptable ratio could be ranked low merely because it did not spend enough money.

o We do not understand why unit cost is given more weight for Part A than Part B (2.25 and 2.00, respectively).

o The weights assigned to the years under comparison are confusing. If the most recent year used is FY84, that year counts for 60% of the total points. But if the most recent year used is part of FY85, FY84 diminishes in importance to only 32.5%. FY84 is still the most recent year for which complete data is available. HCFA should not give 40% credit to FY85 when not all information for FY85 is in. Such credit would make sense only if HCFA waits for all FY85 CPEP data to be gathered and analyzed.

Closed Year vs. Partial Fiscal Year

- We do not believe that HCFA should use partial FY85 data. Contractors have been told that an entire year will be measured, not only part of it and plan accordingly. Cost, for example, can vary over the year, depending on workload and projects. Historically, contractors report higher costs initially and show incremental reductions as the fiscal year progresses.

- MSP goals for FY85 were established unscientifically. During PS&E TAG meetings HCFA agreed to examine contractor MSP experience at the fiscal year end. The partial year methodology would rank contractors before this examination is completed.

- HCFA adjusted the performance level for MR savings at the end of FY84. Based on FY85 performance to date, we assume HCFA will also adjust the MR performance for FY85. Under the partial year method contractors will be ranked before an adjustment can be made.

- Under the assumptions used in developing the methodology, HCFA explains that the partial current fiscal year list will include current data as available. We assume this means HCPA will use the same data, as available for all contractors.

- Contractors operate during a fiscal year with the knowledge of what unit cost must be achieved by the end of the fiscal year. HCFA even set the FY85 cost caps with the end of a fiscal year in mind. Many intermediaries rely on the final quarter of a fiscal year to make whatever adjustments are needed and possible in order to achieve the unit cost goal by the end of the fiscal year. With the proposed methodology, HCFA is changing the rules retroactively by evaluating contractors on partial FY85 unit cost data. This is not only unfair to contractors but may be a mistake by HCFA. For example, at the end of FY85 Contractor A may achieve a lower unit cost than Contractor B even though Contractor B was lower at 3rd quarter's end.

EXHIBIT B

Blue Cross
Blue Shield
of Illinois

233 North Michigan Avenue
Chicago, Illinois 60601-5655
312/938-64[illegible]

Charles R. Goulet
Executive Vice President

January 3, 1986

Mr. Harry P. Cain, II
Administrator
Federal Program Division
Blue Cross and Blue Shield Association
676 North St. Clair
Chicago, Illinois 60611

Dear Mr. Cain:

We have reviewed the draft of the GAO Report on Medicare contracting which you sent to us. We are submitting comments only on those portions of the Report that deal with competitive fixed price contracts, and specifically on the contracts in Illinois. We do not believe that many of the statements in the report regarding the second Illinois contract are based upon factual data, and that the release of the GAO findings as written will have an unwarranted impact on both the Illinois Medicare B Program and Illinois Blue Cross and Blue Shield. We are requesting that you bring our comments to the attention of the GAO.

We do agree with the conclusion in the "Results in Brief" Section on page ii of the Executive Summary "that a major change in the method of contracting used in the Medicare program is not justified because the competitive fixed price experiments have not demonstrated any clear advantage over cost contracts presently used to administer the program. HHS' current authority, if properly used, allows for effective program management and provides sufficient opportunities to achieve greater administrative efficiencies." However, we disagree with significant portions of the GAO report that use the second Illinois contract as a basis to conclude that competitive contracting results in less effective administration of Medicare benefits than is the case under cost contracting.

We do not concur with the statement in the last paragraph on page 15 that reads, "As was the case in the two Illinois experiments, inexperienced contractors may encounter difficulty while learning the numerous, complex and unique requirements of the Medicare claims processing." We also disagree with the GAO statement in the first paragraph on page 18, "HCSC was considered new to Medicare because it had not been a Part B contractor since 1978 and was not completely up-to-date on the program changes since that time." Finally, we strongly disagree with the statement in the second paragraph on page 16 that the performance under the second Illinois contract has been unsatisfactory.

We do not agree that HCSC should be considered an inexperienced Medicare contractor. We have been a Part A intermediary since 1966 and with the exception of five years from 1979 to 1984 were a Part B contractor. Many of our management staff responsible for the administration of Medicare B prior to 1979 were and are part of the Part B management team. Any problems noted by GAO were not the result of an inexperienced management staff but from an unprecedented increase in claims volume and from changes in the Medicare program. Indeed every carrier in our Region experienced similar problems and many did not deal with them in as timely and effective a manner as did HCSC. HCSC was prepared to process claims with a trained staff on April 2, 1984, the contract implementation date, as was evidenced by our ability to pass all volume and quality criteria of the Contractor Acceptance Test conducted in January, 1984. Neither HCFA nor HCSC projected the dramatic increase in claims volume experienced by HCSC and other carriers the first year of the contract. For example, claims receipts increased from 3,242,380 for the period April through September, 1983 to 4,019,326 for the same period in 1984, the first six months of HCSC's contract. This increase of 24% continued during the second six months. Receipts increased from an average of 31,648 claims per day during the first six months, to 36,637 per day in the October, 1984 through March, 1985 period. HCSC processed 1,829,276 claims during the first three months of operation compared to 1,618,411 claims processed by EDSF during the same period the previous year.

We and HCFA both recognized that any delays in claims payment would create serious financial, service and public relations problems for the beneficiary and provider communities, which would impact negatively on HCFA and on the Medicare program. Therefore, expediting claims processing became HCSC's first priority. It should be noted that any increase in the receipts at original entry also dramatically increases volume in all other areas (reviews, telephone calls, correspondence, fair hearings, and professional relations).

We did not hesitate to recruit the necessary personnel to handle the extraordinary workload without any additional funding. Three hundred (300) people were hired and trained to handle the increased volume, and we entered into contracts with keypunch service bureaus to assist us on an interim basis. As a result we were able to maintain our inventories and cycle times at levels acceptable to our Regional Office and significantly below those achieved by EDSF during the implementation of their contract. Simultaneous with the increase in volume we, like other contractors, began receiving a barrage of legislative changes and HCFA initiatives which have had a major impact upon the administration of the Medicare program.

The more significant changes that occurred during this time period were:

- Implementation of fee schedule reimbursement for laboratory services.
- Establishment of "Participating Physician Program."
- Enrollment of physicians in the "Participating Physician Program."

- Mailing and validating of participating physician agreements.
- Modification of customary and prevailing charge levels.
- Freezing charges at the 6/30/84 level.
- Establishment of monitoring and reporting requirements for nonparticipating physicians.

In addition to these changes, which were the result of the Deficit Reduction Act, HCSC also implemented the following:

- Establishment of new claims filing requirements and reasonable charges for all provider based physicians.
- Implementation of procedures and staff to handle Medicare Secondary Payer (MSP) criteria.
- Implementation of the redesign of the Explanation of Medicare Benefits form.
- Implementation of the statistical data system.
- Implementation of additional HCFA prepayment audits.
- Implementation of a savings reporting system for MSP.
- Achievement of electronic media goals.
- Implementation to meet toll free telephone standards.
- **Implementation of the A/B data exchange.**
- Implementation requirements of the regulatory language contained in Chicago Regional Office Intermediary Letters (CRIL's), HCFA Intermediary Letters, Program Memorandum, Carrier Manual Transmittals **and other administrative directives rose dramatically during this period when compared to the same period in 1983.**

All of these changes were in addition to the contractor requirements set forth in the RFP on which HCSC bid. It should be noted that we have yet to receive adequate funding from HCFA for the implementation of these changes, yet all were implemented in a satisfactory and timely manner. In most cases, as is evidenced by our Annual Contractor Evaluation Report (ACER), they were implemented in a manner equal to or better than most cost contractors.

While we did experience quality problems, as did other carriers, these problems did not occur because we were an inexperienced contractor. Problems were caused by the unprecedented claims volume and by the vast number of changes in the Medicare program.

The statement on page 16, that HCSC's performance was unsatisfactory is clearly unfounded. During the first six months of operation, HCSC passed all Contractor Evaluation Program criteria with the exception of the quality standards. We do not believe our failure to meet the quality standard should lead to the conclusion that HCSC's performance should be characterized as being unsatisfactory.

In assessing the quality of claims processing, it should be noted that during the first quarter of our operation, the payment/deductible error rate was 5.3%, not 10.8% as reported in the GAO report. The 10.8% rate reflects a penalty added by HCFA for claims that were not retrieved during the quality assessment audit. We question how GAO determined its estimated mispayment figure and certainly if the error rates used are "with penalty," the dollars reported on page 11 of the Executive Summary and pages 19 and 27 of the Report are grossly overstated. HCSC would like to review GAO's methodology for projecting under and overpayments.

There are also other factors in the Illinois claims mix which impacted HCSC's quality and increased the potential number of high dollar errors:

- Prior to January 1, 1985, a significant percent of the nation's hyperalimentation claims (high dollar value claims) were within the jurisdiction of HCSC. Errors on these claims were included in the error rate calculations.
- Illinois processes 95% of all ESRD home dialysis claims in the nation. These are generally high dollar claims.
- There are many large national supply firms headquartered in Illinois and as a result, HCSC processes an inordinate number of these complex claims.

In spite of the massive changes, processing requirements, volume increases and the factors listed above, HCSC successfully improved its quality rates, as demonstrated by the following comparison with the previous contractor:

Quarters of Operation	EDSF Fixed Price Contract	HCSC Fixed Price Contract
First	6.2%	5.3%
Second	5.8%	3.9%
Third	5.4%	4.8%*
Fourth	4.9%	5.5%*
Fifth	4.0%	3.4%
Sixth	3.4%	2.2%

*Impacted by hiring and training of additional staff and keypunch service bureaus for DEFRA changes and volume increases.

In addition, HCSC's aggressive efforts have yielded quality rates which reflect a 58.5% improvement over those calculated for our initial quarter of operation. Few carriers can match that rate of improvement.

On page 16 in paragraph 3, the Report links Illinois experiments One and Two in such a way as to indicate that HCSC's performance during the transition and operational period was unsatisfactory. We strongly disagree. We do not know the criteria or the national standards of performance GAO utilized in arriving at this conclusion. Further, we do not know the basis for the GAO finding that there were "adverse consequences" (page 16, paragraph 3) to Illinois beneficiaries and providers of health care. HCSC is prepared to present testimony from medical and other professional societies to support our position that there was minimal disruption during the transition and initial operational periods.

Page 18 of the Report contains the following statement; "As stated earlier, EDSF and HCSC experienced similar problems during their respective operational period." GAO should know there is little similarity between the performance of the two Illinois contractors. There were so many problems during the first Illinois contract that Congress conducted special hearings on the contractor's overall performance. The problems identified included:

- Claims and inquiry backlogs.
- Poor telephone service.
- Poor quality of claim adjudication.
- Generally poor service to beneficiaries.
- Non-response to beneficiary and provider letters.
- Failure to implement many HCFA changes in a timely manner.

During the second Illinois contract, there have been no similar problems in either claims or beneficiary services. Telephone service has been excellent and all HCFA and legislative changes have been implemented. Clearly, there is very little similarity between the two operational periods. The GAO Report overlooks the fact that EDSF experienced none of the massive administrative changes or volume increases experienced by HCSC.

We disagree with the statement on page 18, that "all key tasks were not performed as scheduled." In fact, key tasks were internal project goals established by HCSC to meet an operational date of April 2, 1984. The movement or reprioritization of any sub-steps to this April goal were mutually agreed upon with HCFA and, in several cases, were dictated by constraints of the prior carrier. In fact, HCSC began the assumption of workload ahead of the April 2, 1984, date and not only met, but exceeded the contractually specified processing goals in the RFP by processing 529,434 claims during the first month of operation.

In summary, we believe that the GAO Report does an injustice to HCSC's overall implementation and performance to date, as well as to HCFA's role in effectively monitoring the implementation of the second Illinois experiment.

If you have any questions regarding this letter, please contact me or Jack Nutting.

Sincerely,

CRG/ck

STATEMENT OF LUTHER E. CARTER, VICE PRESIDENT, TRAVELERS INSURANCE CO., ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, ACCOMPANIED BY ARTHUR LIFSON, VICE PRESIDENT, EQUITABLE LIFE ASSURANCE SOCIETY

Mr. CARTER. Mr. Chairman, I am Luther E. Carter. I serve as chairman of the Health Insurance Association of America's Medicare Administration Committee.

With me is Arthur Lifson, vice president of the Medicare administration at the Equitable Life Assurance Society.

We appear today on behalf of the nine commercial companies that are involved in the Medicare Program as carriers and intermediaries. We think that Congress used great foresight in commissioning this GAO study. We believe that the report is very factual and that it certainly tells it like it is. The health insurance industry wholeheartedly endorses the report, the conclusions reached, and the recommendations that it makes.

It brings out the conflicting pressures that are being exerted on HCFA and the contractors. HCFA obviously feels that they must produce cost savings in view of the current budget situation. The contractors feel equally accountable to provide reasonable service to beneficiaries at the lowest possible cost, but certainly not at a cost that requires we, as contractors, to subsidize this Federal program, which is happening in some cases. The program is being increasingly underfunded, and very unfortunate results are inevitable.

HCFA has used the DEFRA authority, which was intended for use in dealing with inefficient contractors, across the board with all contractors to reduce their costs regardless of their performance. They have, as my predecessor indicates, effectively changed our cost reimbursement contracts into fixed price contracts without the normal protection afforded by fixed contracts.

The most noticeable result that will happen from this underfunding is delayed claim payments.

Chairman STARK. If I could interrupt, what are the protections under fixed price contracts?

Mr. CARTER. Under fixed price contracts, you would normally have change orders that are specifically negotiated and funded. We do not really have those protections today. Basically we are given instructions to make change on occasion without funds being provided.

As I stated before, the most noticeable result of the underfunding will be the delays in claim payment. If I can make clear what the definitions of delayed payments mean and how long it really takes, then I will have accomplished what I came here to do.

HCFA describes the pending claims in terms of days work on hand. The days work on hand is simply the total inventory of pending claims divided by how many claims a contractor can process a day. This does not tell you how long a period of time elapses from when a beneficiary mails his claim until payment is received.

In our written statement, we have gone into some detail giving some examples of what day's work on hand really means in terms of days. For instance, with a 20-day backlog of claims, you are actually talking about 38 to 40 days it takes to pay that claim. If we are talking in terms of going to 30 days work on hand, as I have just heard, you are really talking about at least 50 days elapsing from the time that claim is mailed until payment is received.

Those are actually calendar days not work days.

Chairman **Stark**. Yes, but they are talking work days so that you get calendar days until the check comes.

Mr. **Carter**. The examples that we have provided in our statement are calendar days.

HCFA has indicated that letting claims backlog will save administrative costs. We, of course, thoroughly disagree with this. Seven of the largest contractors have done a study which shows that allowing claims to backlog for 18 days will generate one-time savings of $5.8 million but that is going to be offset by an annualized cost of $18.2 million. So it costs a lot of money to let claims backlog.

I have not addressed the issue of savings from the trust fund by delaying claim payments. That point was made by the Grace Commission a ways back. The record will show that Congress took an extremely dim view of allowing claims to backlog solely to generate savings from the trust fund.

With respect to the Gramm-Rudman-Hollings amendment and its effect on the 1987 budget, of course it is to early for us to predict what is going to happen. Incidentally, on page 9 of our written statement, there is a typographical error. The numbers should read 958.7 versus 978.5.

I agree completely with Mr. Cardwell that a budget of at least $1 billion will be needed in 1987. If Gramm-Rudman-Hollings is applied and that number is reduced, we are going to face some extremely serious consequences. I have indicated in our written statement the effect that Gramm-Rudman-Hollings has had in fiscal year 1986. Over HCFA's objection Congress has appropriated $978.5 million which was short of the $990 million that we had recommended.

HCFA, as was brought out in earlier testimony, indicated that they needed only $935 million and in fact, requested a rescission of $1.4 million.

The contractors simply cannot process the claims that we are going to receive in fiscal year 1986 with the funds that we now have.

In summary, Mr. Chairman, we would like to recommend that the subcommittee use its legislative and persuasive authority to provide an adequate budget. With that, hopefully HCFA would abandon their arbitrary approach it is pursuing and get back to a budget negotiation process.

We agree with the GAO finding that fixed price experiments have shown no demonstrated advantage over cost-reimbursement contracts and we would recommend that they be discontinued.

We concur that HCFA is using the DEFRA authority inappropriately, and we would recommend that Congress clarify its intent and instruct the Secretary of HHS accordingly.

In conclusion, we would like to commend the GAO for a very thorough professional study of this most important subject. We would urge that Congress give their study very serious consideration.

Mr. Chairman, that concludes our testimony and we would be happy to answer any questions you might have.

[The prepared statement follows:]

STATEMENT OF THE
MEDICARE ADMINISTRATION COMMITTEE
OF THE
HEALTH INSURANCE ASSOCIATION OF AMERICA

I am Luther E. Carter, Chairman of the Medicare Administration Committee of the Health Insurance Association of America (HIAA) and also Vice President, Medicare Administration, for the Travelers Insurance Company. With me is Michael Schaub, Vice-President, Nationwide Mutual Insurance Company; Mr. Arthur Lifson, Vice President for the Equitable Life Assurance Society; and Geza Kadar, Assistant Washington Counsel for HIAA. We appear on behalf of HIAA's Medicare Administration Committee representing the nine member companies [1/] that have served as Medicare carriers or intermediaries since the inception of the Medicare program in 1966.

The Medicare program has been a successful, cooperative effort, jointly administered by the federal government and private companies on a contractual basis of no profit/no loss. Medicare contractors handle an enormous workload -- an estimated 360 million claims and in excess of $70 billion in benefits in FY 1986 -- providing a high level of service with dependable quality controls, incurring administrative costs of 1.3% of benefit payments. This is a truly remarkable record and a tribute both to HCFA and the private sector contractors who operate the program. Medicare is one of the few government programs that has continuously and consistently demonstrated reduced administrative costs.

Despite the program's past success, a crisis of major proportions may be in the making. Because of the cost-cutting and related changes implemented by HCFA, the Medicare program has developed serious problems. As claims administrators contracting with the federal government, we endeavor to provide prompt quality service to millions of elderly beneficiaries at the lowest possible cost.

Until three years ago, we achieved this fundamental objective through a cooperative effort with the federal government. However, this cooperative effort has begun to break down and is being replaced at times by an adversarial relationship. The success achieved in the Medicare program over the years was based on mutual trust between the Medicare contractors and the government, a very necessary ingredient for a program of this nature.

HCFA has focused so earnestly on cost cutting that it has begun to act in isolation. The Medicare program's administrative costs are increasingly being underfunded and unfortunate results are inevitable.

That is why this hearing is timely and important. The Health Subcommittee's press release of April 11 requested that witnesses respond to five major points, all of which are addressed in the GAO's recent report, Medicare Contracting: Existing Authority Can Provide for Effective Program Administration.

[1/] These companies include: Aetna Life & Casualty; Connecticut General Life Insurance Company; Equitable Life Assurance Society of the United States; General American Life Insurance Company; Mutual of Omaha Insurance Company; Nationwide Mutual Insurance Company; Occidental Life Insurance Company of California; Prudential Insurance Company of America; and The Travelers Company.

The health insurance industry wholeheartedly endorses the GAO's report and its conclusions. We further commend the GAO for its very thorough and professional study of this pressing subject.

Congress directed GAO to prepare this report. Honest differences of opinion between the Medicare contractors and HCFA exist during this period of intense budget reduction. We and HCFA come at the issue subject to incompatible pressures:

- o Charged with helping to reduce the federal deficit, HCFA officials feel acutely accountable to produce demonstrable savings; and
- o Faced with a growing volume of claims, Medicare contractors feel equally accountable to preserve a reasonable level of service for Medicare beneficiaries, but not at a cost that requires the contractors actually to subsidize the federal program.

The issues being examined by the Subcommittee raise important public policy questions: Are the contractors' and HCFA's objectives fundamentally irreconcilable? The answer is, and has been, no. Can services be maintained at an acceptable level at a reasonable cost? The answer is unequivocably, yes.

Although improvements are always possible, it should be obvious that there is no excess in this administrative program. We believe that is why HCFA abandoned budget negotiations with contractors, resorting instead to wholesale directives that all contractors -- good or bad, operating cost-effectively or not -- reduce administrative costs to arbitrary levels. This is a major departure from established procedure -- indeed an apparent violation of existing contracts. Our cost reimbursement contracts are effectively being transformed into fixed price contracts, without the protections normally incorporated into fixed price contracts. HCFA has unilaterally imposed upon the Medicare contractors "capped" unit costs for the claims processing operation. HCFA has supplanted cooperative budgeting, a hallmark of the Medicare program, with a rigid program where costs are established by fiat precisely because the program is already operating on such a cost-effective basis.

The Medicare Administration Committee and the companies it represents endorse reducing the federal deficit. But unavoidable questions arise: Who will shoulder the burden of these arbitrary cost reductions and are their purported savings illusory?

1. Elderly beneficiaries will share the cost of these budget reductions.

Unavoidably, the cost reductions will be made up in significant part by slowing payments to elderly beneficiaries. Beneficiaries will subsidize the budget reduction by virtue of a "float" (an interest-free loan) imposed by the federal government. Recent press statements indicate that HCFA understands this consequence and, in the opinion of many, intends it.

The issue for Congress is whether the budget savings derived from delayed payments justify the burden that will befall the beneficiaries and providers of services. The suggestion to slow payments was one which the Congress roundly criticized in the

Grace Commission Report. It is a highly questionable practice -- and in some forms, is an indictable offense when practiced by corporations. It is difficult to see how the Congress can endorse this practice when it is used against our elderly Medicare beneficiaries. In fact the Senate Appropriations Committee is on record stating that:

> The Committee believes that an adequate funding level for Medicare administrative functions is essential to maintaining the integrity of the Medicare Program and to assure the timely and accurate processing of claims. Further the committee believes...that first priority should be given to the claims payment functions to reduce claims backlogs and to prevent any further deterioration in the quality and timeliness of claims processing functions. 1/

At this point, an explanation of what claims backlog means to the beneficiary is in order. Historically, the backlog or inventory of claims ranged from 6-10 days. HCFA plans for it to grow to 18 days in FY 1986, and subsequently to 22 days in FY 1987.

HCFA uses the term "days work on hand" (DWOH) to describe the backlog. This simply means the total pending claims divided by the contractors' average daily processing capability. It does not provide a measure of the time it takes from when a beneficiary/provider mails a claim until payment is received. The following table provides a realistic picture of the actual calendar days required with a 20-day backlog of claims:

Payment Cycle in Calendar Days

	BEST CASE	WORST CASE	AVERAGE
Mail from Beneficiary/Provider	1.0	4.0	2.5
Mean Processing Time (average) @ 20 DWOH	24.3	24.3	24.3
Summary Check Cycle	0.0	14.0	7.0
Mail Room -- Print, Sort, etc.	2.0	3.0	2.5
Mail to Beneficiary/Provider	1.0	4.0	2.5
Total	28.3	49.3	38.8

As seen from this example, at 20 DWOH, it takes an average of 38.8 days to get payment to the beneficiary/provider. This is extremely burdensome for beneficiaries, and it actually produces a new set of administrative costs. Providers go into the next billing cycle, producing duplicate claims. Beneficiaries and providers inquire about the claims in record numbers. Even today, it is almost impossible to improve telephone service fast enough to keep pace with the calls.

The delays become further distorted when one considers Electronic Media Claims (EMC). Since they process through the system rapidly, the other claims must age far beyond the above averages to maintain the required DWOH.

1/ U.S. Congress. Senate Appropriations Committee. FY 1986 Appropriations Report. October 4, 1985.

2. The purported savings are illusory.

HCFA has indicated that allowing DWOH to build was done to save costs. The Medicare contractors have continually pointed out to HCFA that the opposite is true. Seven of the larger contractors, representing 40 percent of the Part B claims, conducted a study of the costs vs. savings. Extrapolated from the study, figures show a backlog of 18 DWOH will generate a one time savings of $5.8 million but will be offset by an annualized cost of $18.2 million. These are very conservative figures, in that all areas that could not be quantified were eliminated. This study was presented to HCFA several months ago.

Delaying claims payments for such lengthy periods causes many adverse reactions, such as submission of duplicate claims where payments are not made within 30 days, beneficiary/provider inquiries, reduced assignment rates, lack of physician participation, reduced submission of electronic claims, and poor contractor image. The backlog which HCFA's budget process necessitates is even causing some contractors to remove corporate identification from their Medicare claims.

In a recent budget hearing before a Senate Appropriations Subcommittee, [1] HCFA testified that delaying the payment of claims was encouraged and supported by the Prompt Payment Act (P.L. 97-177). We strongly disagree. This act was clearly intended to encourage prompt payment. Prompt payment laws of various states require claim payments be made within 10 to 15 days. While this varies by state, none of them would accept 38 to 40 days for payment.

Finally, we were asked to comment on the impact of The Balanced Budget and Emergency Deficit Control Act of 1985 -- the Gramm-Rudman-Hollings Act, P.L. 99-177 ("GRH") on FY 1987. HCFA is blaming GRH for the rapidly deteriorating claims service. In fact, there is no causal connection.

In FY 1986, HCFA requested/received $920 million plus a $15 million contingency for Medicare contractors. The Congress then appropriated $978.5 million with strong report language directing HCFA to improve the claims service to beneficiaries/providers. HCFA subsequently advised the Medicare contractors that additional funds over the $935 million were not needed and a rescission would be requested. Concurrently, Congress passed GRH, and a 4.3 percent reduction was imposed on the $978.5 million, leaving $936.4 million -- a total that is greater than HCFA had actually intended to utilize. (HCFA later did request a rescission for the difference of $1.4 million.) Therefore, it is inconceivable that HCFA should lay the responsibility for poor claim service in FY 1986 on GRH. The contractors will be unable to process the volume of claims anticipated in FY 1986 without restoration of funds to $978.5 million level.

In its FY 1987 budget for Medicare contractors, HCFA requested $958.7 million plus a $50 million contingency. (The recently passed Consolidated Omnibus Budget Reconciliation Act of 1985 -- COBRA -- includes an additional $60 million for audit, medical review, secondary payor, etc.)

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[1] U.S. Congress. Senate Appropriations Subcommittee on Labor/HHS/Education. Hearing. Washington, D.C., March 18, 1986.

At this stage in the congressional process, we do not know what the effect of GRH will be in FY 1987. We do know that, in FY 1986, the mandatory reduction required by GRH yielded inadequate funding. We also can state unequivocably that $978.5 million is totally inadequate to handle the volume of claims expected in FY 1987. HCFA has consistently underestimated the growth in claims volume which has historically increased at the rate of at least 10 percent per year. Further cuts would only exacerbate the problems of an already intolerable situation. We predict that a budget of $1 billion or more in FY 1987 will be required to avoid serious problems.

Conclusions and Recommendations

Congress used great foresight in directing GAO to review these issues. The Congress provided the GAO with a carefully defined assignment, wholly within GAO's competence, and a reasonable time frame within which to do a thorough job. If an independent arbiter were not presenting these findings, they might be received skeptically. However, there is every reason for the Congress to accord full deference to the GAO's findings in this case.

We fully support the recommendations made by GAO. We would offer the following recommendations:

1. This is one of the Government's most cost-effective administrative programs. We recommend that the Subcommittee exercise its legislative and persuasive authority to provide a medicare contractor budget that is adequate. Proper funding will require HCFA to abandon the arbitrary approach it now pursues and return to a budget negotiating process with the Medicare contractors that places emphasis on individual circumstances and provides adequate funds to process claims promptly.

2. We agree with the GAO's finding that fixed price contract experiments have shown no demonstrable advantage. Therefore, we recommend that future use of such contracts be limited if they are used at all.

3. We concur with GAO that HCFA's use of the DEFRA authority to deal with cost inefficient contractors is inappropriate and inconsistent with Congressional intent. We recommend that Congress clarify its intent and instruct the Secretary of HHS to act accordingly.

4. We have no objections to the GAO recommendation that HCFA use its existing authority to remove consistently poor performing contractors.

I will be happy to answer any questions the Members of the Subcommittee may have.

Chairman Stark. Thank you both.

Let me see if I can get Blue Cross/Blue Shield and the private insurance companies in the same box here for a minute.

You are both intermediaries for part A. Correct?

Mr. Carter. Some companies are.

Chairman Stark. And you are both, and I am talking about some hypothetical insurance company here and some hypothetical blue plan. You are both in the business of providing a private hospital insurance that would cover the same sort of procedure as part A.

Now, what I am going to try to find out from you is, if I can go back to my gall bladder removal, in a private plan, whether it is for a union plan or just something that an individual buys from either of you, you have a hospital payment portion which could be comparable to our part A, DRG, is that fair?

Mr. Carter. Not exactly.

Chairman Stark. I understand that in many cases, you may pay so many days and be a little more open-ended but still there is going to be a claim for this hospital portion of the gall bladder removal, correct?

Mr. Cardwell. We both make payments to providers for services rendered. We may send the money through a different route. Blue Cross/Blue Shield plans tend to do it directly and most commercials tend to do it through the beneficiary.

Chairman Stark. Back to the beneficiary. That is what I wanted to get at here for a minute. What I would like to find is if there is a procedure where a private insurance company and Blues are paying to the provider for what would be the equivalent of our part A, DRG. What is different in the way that you would pay that kind of a claim from the way that you process a Medicare claim?

That is what I am trying to get at.

Mr. Lifson. There may be several differences. In my own company, it does and has, in fact, entered into a series of contracts with a number of hospitals that pay them in a preferred provider arrangement on a DRG basis. First the DRG that we are using is a different DRG than the one that Medicare is using. It is a little bit different in its amount and it is also a little bit different in its composition.

Chairman Stark. How about the time taken to pay and the cost of processing the claim?

Mr. Lifson. The time for processing and paying the claims we use is a much stricter standard than Medicare has. And in fact, there was a survey done by the HIAA and if I could summarize it, I would say that 90 percent of the companies use a standard for themselves, that 90 percent of the claims be paid in no more than 15 days.

Chairman Stark. Are your costs higher for processing that claim?

Mr. Lifson. The costs of processing the claim is a little bit higher because each plan of benefit that we administer is different. In Medicare, you have a single plan of benefits. Under our plans there will be varying coinsurance and deductible amounts and other things like that, that will make the claim a little bit more complicated.

Chairman Stark. OK. How about in the case of the Blues?

Mr. **Cardwell**. We have some arrangements where we use a DRG payment method but it too uses a different DRG than the Medicare DRG.

Chairman **Stark**. But how about just in terms of processing?

Mr. **Cardwell**. The processing would be essentially similar in those cases, except and we do the same thing Medicare does—we make periodic payments to the provider and then we settle up at the end of operating periods.

The methodology would be very similar.

Chairman **Stark**. Please, yes?

Mr. **Lifson**. I have just one minor point. About 90 to 95 percent of all hospital claims are assigned, which means the insured has assigned the benefit over to the provider. So, in essence, the payments are going directly to the providers. There are some arrangements for doing that electronically as has Blue Cross and Medicare.

Mr. **Cardwell**. We generally—one of the things that sets us aside from the norm is, we tend to negotiate with providers in advance as to what we will pay them. The DRG arrangements differ from those arrangements. And we, too, have a standard; all member Blue Cross plans are required to maintain a standard processing performance of 90 percent in 14 days.

Chairman **Stark**. How many hours a day?

Mr. **Cardwell**. But there again, there is a difference between our processing time requirements of 14 days and the timing of the actual payments.

The timing of the actual payments are regulated on a different time scale and they are very often negotiated.

Chairman **Stark**. Do you see any benefits, any of you, in our going, and I am not suggesting federalizing, but going to a standard format and computer program?

Does that create problems for all of you or would it, in the long run, tend to simplify?

Mr. **Carter**. That there are differences between the types of claims and I am not sure that would work as well as it might seem on the surface. Earlier today, you were talking about the wide range of costs that exist between intermediaries. I think that range may have come together quite a lot since the GAO report was issued. You have a lot of things like the mix of providers that we handle. A hospital might generate more claims than 25 skilled nursing facilities, yet the administrative effort that you have to put into each one of them might be almost identical.

The degree of automation can make a big difference between hospitals, for example, large hospitals as opposed to rural ones.

So there are a number of things that cause substantial differences in cost of processing claims.

Chairman **Stark**. OK.

Mr. **Cardwell**. It seems to me, Mr. Chairman, that there are advantages to having standardized formats and I think HCFA has moved steadily in the direction of doing that.

I think that they lost some opportunities through the years to standardize the basic automated claims processing systems themselves so that they could have common maintenance procedures and the like.

At this stage, I think that it would be very difficult to convert the whole system to a standard automated system. I go back to Mr. Daub's point. This arrangement is one that is most successful if it is stabilized. Experience shows that any time that you convert from one intermediary or carrier to another one, whether it is from a commercial to a Blue or from a Blue to a Blue, whatever the arrangement, you pay a price for it and you do not necessarily obtain a better performance. In the case that he speaks to, involving Iowa and Nebraska, the timing was such that the Iowa plan was going through some major systems changes for its regular business and I think that probably got caught up in the Medicare changeover as well. But nonetheless, that has always been the experience and everybody pays a price, particularly the beneficiary.

Chairman **Stark**. Is this a particularly profitable business for you guys?

Mr. **Cardwell**. No carrier or intermediary is making any money on this business at this time. It is being subsidized by Blue Cross & Blue Shield plans today in many places and they continue to carry it because they want to identify with this part of the community.

They cannot carry it assuming that the thing will work itself out and some proper level will obtain. I have been able to observe it for 20 years and it has shown a very steady state of improvement, increased efficiency and productivity and lower administrative costs. I think that we have now forced the costs in the low end of the spectrum down to rock bottom. I think that if we try to force the bottom any further, we really are going to be disruptive and in the long run pay new prices for it.

I am sure that the argument that they have not lost any contractors is a very compelling one from your side of the table. But I do not think as a person on the other end of the business now that the Government is a reliable partner with whom to contract. And if you were to ask me, as I thought that you might, what would we think of capitating, I can theorize that capitating would be a very efficient system but I would be very frank with you, I would not trust the Government to carry their side of it fairly.

Once we agree on a capitation rate, if you lower the money available, because you have such tremendous leverage, you are paying 40 percent of the medical bill in this country, when you lower the amount that you are willing to pay and insist on the same benefits, the contractor gets caught in the crunch.

And that is what is happening now in Medicare.

Chairman **Stark**. Just on the——

Mr. **Carter**. I was just going to say that the program has been administered since the beginning on the basis of no profit/no loss. And it is getting to be more no profit and sure loss as time goes on. We are often given the statement that the cost can continue to go lower and will be driven lower until there is "blood on the table," in other words, until a number of contractors drop out, the feeling is that the cost can be driven even lower.

Chairman **Stark**. What is the incentive? I can maybe see some of the Blues where you have a large percentage of the business in the community but what is the incentive to a commercial insurer to stay in it?

Mr. CARTER. Well, that may be one of the answers in itself, sir, in that we certainly do not want to see the Blue Cross and Blue Shield have a monopoly in this instance.

Chairman STARK. Would you guys really raise hell with us if we said, let's federalize it?

Mr. CARDWELL. Well, as a practical matter, as a matter of public policy, I do not think that would be a very good idea. You would transfer $1 billion administrative cost to the Federal payroll. It just does not seem politically doable.

Mr. LIFSON. There was at one point, as you may recall, where HCFA did pay claims directly. It was not done efficiently and it was never of a significant enough size to really do it well.

I think that past experience would show that you would probably end up coming back in some way and having exactly the same people perform the same function.

Mr. CARDWELL. And right now, you are drawing on the overhead and the experience base of the private sector.

Chairman STARK. And I appreciate it. It seems to me that there are two segments to the processing of these claims and maybe I am way off base, but a lot of it is not a whole hell of a lot different than processing a Master Charge or VISA checks.

Mr. LIFSON. Can I address that?

I really think that there is a big difference.

Mr. CARDWELL. Yes, I do, too.

Mr. LIFSON. A check or a MasterCard charge or something like that, you are dealing with a number, with a finite item, and it does not take a lot of training and so on for a data entry person to transcribe that number from one to the other into the system.

Here we are dealing with medical matters and with what has happened in people's lives. We are making judgments about, at a minimum, what box they are falling into on the DRG's, and the types of services and the appropriateness of the services that they have received.

Chairman STARK. I have no quarrel with that.

Mr. LIFSON. Can I then just take it another step further. What you are really paying for, is for people who are entering the data into the system, to use their judgment about the claim that is in front of them. There is a lot of editing if you put it in computer terms, there is a lot of editing that goes on within the person putting the data into the system, that is No. 1.

And I really know of no system that can adjudicate and go back and say, this is really an appropriate claim, and this really happened to this person and so on without people intervention and——

Chairman STARK. Sort of like a loan officer who makes a defense against going to credit scoring.

Mr. LIFSON. Well, certainly there are parameters that you can kick it out.

Mr. CARDWELL. There are a number of variables, I am guessing, but I would guess that the number of variables in processing a Medicare claim compared to a bank card claim would be 50 to 1.

Chairman STARK. OK, I am with you there, but go ahead and then let me speak.

Mr. CARTER. Mr. Chairman, this type of thinking took place several years ago, when the first Illinois experiment took place and the contractor was not familiar with processing claims. One only has to study the results of what happened there to see that processing claims is not merely and simply a mechanical——

Mr. Cardwell. That one involved conversion from a Blue Cross & Blue Shield plan to a noninsurance administrator and that administrator had a very good record of perfecting a basic processing system that had screens in it. It would screen out the things to be looked at by individuals. His efficiency quotient on that was very high compared to ours but where he got into trouble was when the screens kicked something out and somebody had to pick it up and intervene. And that is where the process gets complex and that is where it costs a lot.

Chairman Stark. OK, but what you are talking about took place under a kind of historic reimbursement program, the old look-back system. And we are moving for better or worse to a DRG system. So that——

Mr. Cardwell. Well, you are a long way from DRG's for physicians.

Chairman Stark. But I am just talking about part A, now for a minute. And so am I not correct that once you get into a 100-percent DRG, you are taking a lot of the judgment and auditing——

Mr. Cardwell. No, because in Medicare, there are a whole set of rules that are handed down by HCFA to the contractor that say, you can pay for this, but you cannot pay for that. It is the you can pay for this and you cannot pay for that determination that also applies to a DRG. All the DRG does is simplify the determination of the amount to be paid once it is decided the claim is payable.

Chairman Stark. I guess what I am getting at and maybe you have the same system, but it seems to me that the hospital is in most cases, like a large hospital that has data processing capability——

Mr. Cardwell. And a lot of claims are processed automatically from hospitals to intermediaries.

Chairman Stark. And is that not more efficient?

Mr. Cardwell. Certainly, yes, there is no question.

Mr. Carter. Mr. Chairman, you keep referring back to the part A claims. One of the things that you have to realize is that there are two methods of paying hospitals. First, we talked about the periodic interim payments and of course, there are claim payments, but basically claim payments are interim payments, if you will, because ultimately we come back and audit the hospital's costs to determine what is really owed to them.

Chairman Stark. But you keep saying costs, but you see that is about to disappear. Soon you are just going to come back and audit their classification process and give them a fixed unit price.

So the old idea of cost is going to disappear.

Mr. Carter. I understand.

Chairman Stark. OK, I am still with you. If you limit it to part A, which I understand a little better than part B, and if you are talking about a world which is going to be all DRG's, and forget the outliers and some of the other things, then I am getting the feeling that the process people are cranking through a lot of forms and reentering. It seems to me that the person at the hospital, once that data gets entered, ought not to be fussing around with reentering it at each step along the way.

Mr. CARDWELL. Where we are dealing with large and sophisticated hospitals in major communities, automation has progressively moved into place. But we have 7,000 hospitals in this country, many of which are in small communities and lack the capacity to communicate on an automated basis with the claims processing system whether it is a Federal site or whether it is a contractor site. There is some optimum level of automation and I am not saying that we have reached that optimum level but there is also always going to be a large number of situations where you have to rely on fairly old-fashioned techniques.

Chairman STARK. Do you not think that if it was a question even in the smallest of the small hospitals, between their getting current credit, in their bank account if they just buy a modem and just put it in over the phone?

Mr. CARDWELL. It is doable. I would not want to say that it is not doable.

Chairman STARK. That they are going to move very quickly toward putting terminals in and input directly if they are going to get instant credit. It is just like the retailer that gets instant feedback on card approval. If he can crank merchandise past that profit line a lot faster, it becomes better and I just wonder——

Mr. CARDWELL. As my colleague just pointed out, if you look at the whole program, part B is a very significant share and there you are talking about individual physicians and the capacity for them to deal on an automated basis. While it is growing, it is still very limited.

Chairman STARK. Mr. Daub.

Mr. DAUB. No questions.

Chairman STARK. Let me see if it is a fair summary, and I keep looking for ways that we can, in a technological sense, save some money, and I get the feeling that you guys are saying that we have pushed you far enough in that direction, and the returns would be fairly marginal, if a claim cost is going from $3 to $4, we have got to pay the $4, or you guys are not going to do it, and then we are going to end up federalizing by default.

So we are just trying to chintz in the area of paying for this processing, and——

Mr. LIFSON. It has not gone from $3 to $4. It has gone from $3 to $2.50, and HCFA only wants to pay $2.

Chairman STARK. Look, it is the same thing we are dealing with. I mean, each year, I am forced to find ways to save money. I can save 20 percent of the program by freezing.

You can do that so long, and it atrophies. I mean, that is all, and, that is not very creative. You know, it is a way to save money but it does not answer——

Mr. CARDWELL. I think you should continue to monitor the system. I think you should continue to press both the contractors and HCFA to perfect the systems. There is still room for improvement, as always. New capacities are always there to be applied. But it should be done in an orderly, balanced, and careful way.

This program has had an excellent record through its 20 years in terms of beneficiary acceptance and recognition. I think we are beginning to put that into some sort of jeopardy. If I were a Member of Congress, I would be very concerned about that possibility.

Chairman **Stark**. Do either of you want to comment on what happens if we go to a voucher and capitation? Are we prepared to supervise that and deal with it?

Mr. **Lifson**. As an industry we have examined vouchers and we continue to examine the question. It is on the table and is something that is going to take a lot of thought. The example that you gave, unless there is real care given in how—to assure that people are really going to provide the benefits, and that the Medicare Program itself is not selected against, that the HMO's, PPO's, CM—whoever they are--insurance companies only take the healthy risk. Within any classification system, it is generally an average, and people are entrepreneurial enough to find out who is what, and how. I would be concerned about the program itself and its longer term viability, if you had a total voucher——

Chairman **Stark**. Can you feature what you would do, for instance, if you want to talk about selection, and you were out hustling to sign up people under the voucher and the HMO, if you just sorted out homeowners from renters, or just sorted out those people who do not have a telephone from those——

Mr. **Lifson**. I mean, I can give you a thousand ways to redline this system.

Mr. **Cardwell**. I think the experience of at least some of the experiments that have been done in the past would show that how one markets it, which is in part what you are saying, has a material impact on the financial results of the plan.

Chairman **Stark**. Driver's licenses. You know how we select out against people who should not drive. A lot of that is done for you, if you really want to be creative in a way to cherrypick in a system like that.

Mr. **Daub**. Mr. Chairman.

Chairman **Stark**. Mr. Daub.

Mr. **Daub**. I did want to ask Mr. Cardwell if he would look into my concern that I have raised.

Mr. **Cardwell**. Yes, sir.

Mr. **Daub**. It has been looked into to some extent, but we are just still having trouble.

Mr. **Cardwell**. I will talk to them.

Mr. **Daub**. And I do appreciate all the cooperation that we can get on a number of things that we do with your company, but I can tell you: this one does not seem to be progressing fast enough.

Mr. **Cardwell**. We will get a comment back to you.

Mr. **Daub**. I am not on a witch hunt, but the other response is this: "We've answered your questions." This then prompts, "Well, I guess it's time to issue the press release." I do not want to play the game that way, so I would very much like to have some more attention paid to this transition and getting some of the rough edges off.

Mr. **Cardwell**. Right.

Mr. **Daub**. "My district manager's going nuts with all the phone calls that he's getting."

Mr. **Cardwell**. Fine. We will get back to you, quickly.

Mr. **Daub**. I appreciate it very much. Thanks.

Chairman **Stark**. Thank you all very much, and I am sure the staff will have some questions, the prepared questions that I did not get to ask you, that they would probably like to have submitted to you and we will appreciate your answers for the record.

Our final panel consists of Dunlop Ecker of the American Hospital Association, and president of the Washington Hospital Center; William Felts, chairman of the council on legislation for the American Medical Association; and Ronald Kovener, who is vice president of the Healthcare Financial Management Association.

Gentlemen, our timing device broke, and I am going to ask you to constrain your zeal and enthusiasm to as close to 5 minutes as you can imagine, and proceed in the order in which you appear on the witness list.

Mr. Ecker, if you would like to go ahead, in any manner you are comfortable with, you may proceed.

STATEMENT OF DUNLOP ECKER, PRESIDENT, WASHINGTON HOSPITAL CENTER, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. **Ecker**. Thank you, Mr. Chairman. I am pleased to present a brief summary of the testimony in the statement issued by the American Hospital Association on the issue of Medicare contracting.

Budget pressures have severely squeezed the ability of HCFA and fiscal intermediaries to process claims in a timely manner. Slowing down the payment cycle, in our judgment, will not produce budget savings.

It will in fact increase hospital costs for those hospitals that must borrow for financing payroll and other costs.

In other words, costs will be shifted from the public sector to the private sector. Medicare's administrative systems have not kept pace with recent changes in Medicare payment policy.

Consequently, hospitals are at the mercy of policies and procedures that are frequently unclear, and subject to substantial variation and interpretation.

The periodic interim payment program is valuable to hospitals and should be continued. PIP helps to ensure adequate cash flow to hospitals during delays that are beyond the hospital's control. We believe it is appropriate to update PIP eligibility criteria, but we question, and do not support merging PIP and EMC, which may cause providers who most need PIP to be ineligible for the payment program, particularly the smaller hospitals.

The proposed elimination of fiscal intermediary nomination and the substitution of competitive bidding pose significant problems.

Claims processing requires a high level of expertise and established channels of communication for smooth functioning. In some States, there have been significant problems in timely processing of bills under the competitive bid process.

AHA has undertaken a comprehensive review of administrative arrangements and has proposed several performance standards that should guide future work.

Namely, information collected should be valuable to users; performance standards should be set; the process should be understandable and timely; and reports should be integrated.

In conclusion, Mr. Chairman, it is clear that the Medicare Program is in a state of flux. This does substantially increase the uncertainty and confusion of patients, providers and administrative agents, and we believe that a concerted effort will be required to hold this confusion to a minimum level. Thank you.

[The prepared statement follows:]

American Hospital Association

444 North Capitol Street N.W.
Suite 500
Washington D.C. 20001
Telephone 202 638 1100
Cable Address: Amerhosp

STATEMENT
BY THE
AMERICAN HOSPITAL ASSOCIATION
ON
MEDICARE CONTRACTING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS

April 22, 1986

On behalf of its 6,100 member hospitals and 35,000 personal members, the American Hospital Association welcomes this opportunity to comment on recent developments in the administration of the Medicare program. As you are aware, enormous change has characterized the Medicare program over the past several years. Not only has the adoption of DRGs revolutionized the Medicare payment system for acute inpatient services, but changes in medical technology and medical review have resulted in a shift from inpatient to outpatient settings. At the same time, payment policies for outpatient services have been in a constant state of flux. The administrative systems of Medicare have failed to keep pace with these changes. Fiscal intermediaries have struggled--along with hospitals--to keep track of ever shifting policies and procedures established by the Health Care Financing Administration (HCFA). HCFA itself has struggled to keep pace with the rapid changes in the Medicare statute that have resulted from congressional efforts to reduce program expenditures. The result has been policies and procedures that are often unclear and subject to substantial variations and interpretations at the local level.

Moreover, many of the policies and procedures established by HCFA were designed with the needs of a cost-based reimbursement system in mind. The basic functions of the cost report and billing form have changed with the institution of the Prospective Payment System and the other changes adopted by HCFA. They can be expected to change further as the payment system and delivery arrangements evolve. The cost of complying with these changes is substantial, and is assumed by providers, fiscal intermediaries, and HCFA. It is, consequently, essential that renewed attention be focused on the program management to minimize these costs and to reduce unnecessary confusion for both beneficiaries and providers.

PAPER SAVINGS

Recently, hospitals have been disturbed by directives from HCFA which will have the effect of slowing down the payment cycle. The principle goal of the government appears to be saving money. However, the savings produced by slowing down the payment cycle are an illusion. Eventually these claims must be paid, and in the meantime the payroll and other costs of the hospital must be financed by borrowing. For example, if Medicaid delays payment by two weeks, which according to reports from some regions of the country is exactly what has happened, hospitals must increase short-term borrowing by nearly $2 billion at an annual interest cost of over $125 million. These additional costs are not reflected in the DRGs prices, which were based on a considerably shorter payment period. A policy of slowing down payment simply increases interest costs and shifts them from the public to the private sector. This is taxation as assuredly as an outright increase in personal or corporate income or payroll taxes would be.

CLAIMS ADMINISTRATION ISSUES

Over time, the Medicare billing and claims adjudication process has grown in terms of the data that is collected on the patient bill and the steps that the bill must go through. This growth has been spurred by attempts on the part of the Medicare program to protect program integrity and to respond to changes in the payment system. Since the introduction of Medicare PPS, fiscal intermediaries, along with hospitals, have had to restructure their administrative systems. Fiscal intermediaries are now performing many more functions than they were prior to the introduction of PPS, and PPS is not the only change with which they have had to cope. In fact, the pace of changes continues to accelerate with each year's budget cycle.

The intention of other, more recent, HCFA efforts is to reduce the speed with which payments are made. HCFA's objective is to improve the program's short-term cash position. These efforts include:

1. setting an arbitrary timeframe for remittance of payments by fiscal intermediaries;

2. reducing access to payment files;

3. reducing the numbers of bill processing sites and budgetary cuts that result in the elimination of bill processing personnel; and

4. reducing the billing options available to providers, i.e., paper claims, combined billing, electronic media.

Billing and payment issues raised by these efforts include:

- increasing the volume of data that must be submitted for billing purposes and medical necessity and utilization review decisions by Peer Review Organizations (PROs);

- delaying receipt of Medicare benefits and eligibility from fiscal intermediaries; and

- delaying claims processing by fiscal intermediaries.

Eligibility and Billing Procedures

HCFA is also looking at various ways to improve its own cash position and to streamline the claims adjudication process. Often this has been accomplished by shifting various claims processing responsibilities from fiscal intermediaries to hospitals. For example, HCFA is planning to eliminate the Medicare notice of admission or benefits query process. It is currently working toward a national implementation date of November 1, 1985. Five pilot projects began with the new program in early summer of 1985 and already four states have eliminated the notice of admission. HCFA envisions this process will generate substantial administrative savings and will streamline the claims adjudication process. Such streamlining is possible but uncertain. Until a proven system is available, implementation should proceed only on a pilot basis and only after adequate consultation with providers. It is particularly important for HCFA to develop an efficient system for timely determination of beneficiary eligibility and to eliminate confusion and uncertainty for both the patient and provider.

Emphasis is being placed on moving providers to electronic medical claims (EMC) submission. Each intermediary has an EMC goal to meet as part of its standards for contractor performance, and the intermediaries are working aggressively to achieve their goals. EMC is a worthwhile goal, but at this time it is only that--a goal. Many small hospitals, in particular, will have to make substantial changes in their data processing systems which are costly and very possibly not cost-effective. In pursuing greater administrative efficiency for itself, HCFA must not force hospitals to reduce their own efficiency. Funds are limited and must be spent where they will yield the greatest benefit to patients and communities.

Periodic Interim Payment (PIP)

HCFA is also examining the eligibility criteria for PIP, and HCFA officials have previously indicated their intent to institute EMC as an eligibility requirement. HCFA is also attempting to control the level of PIP overpayments to providers. At least one HCFA regional office has issued instructions which tighten the requirements that allow a provider to remain in PIP, including a history of overpayments, data accuracy, and timeliness of data submission.

During the past two years, HCFA has attempted to restrict eligibility for PIP. The new criteria, which have not been formalized in either regulation or administrative issuance, have been publicized only through regional office and fiscal intermediary correspondence and have been enforced to varying degrees by each intermediary. The only formal national change to PIP eligibility criteria is a recent requirement for hospitals to submit at least 85 percent of their claims within 30 days of discharge.

Recently, HCFA has proposed to add to existing PIP eligibility criteria the requirement that providers submit claims electronically unless the provider's request for an exemption is approved. The major impetus for this new criterion is projected program savings resulting from improved claims accuracy and more efficient claims processing systems.
AHA has long supported the continuation of the PIP program. We recognize the need to update PIP eligibility criteria and to improve the administration of the program. We have also been supportive of EMC submission and have provided comments and suggestions to HCFA on numerous occasions on how to encourage EMC use. However, we do not support this latest proposal. The merging of these two programs - PIP and EMC - does little to improve the effectiveness of the PIP program, nor does it increase the attractiveness of EMC. While the proposed requirement may force some providers to use EMC, it essentially causes those providers who may most need PIP to be ineligible for this payment program.

From the hospital's perspective, there are several reasons why the PIP program should continue to be available, including:

- the inability of hospitals to control timeliness of the fiscal intermediary's claims adjudication and payment process;

- untimely payment on direct billing or unpredictable receipts for Medicare claims;

- constant additions and modifications to Medicare billing requirements which result in difficulties and higher costs for both providers and fiscal intermediaries;
- the need to minimize the interest expense of financing accounts receivable and to offset working capital expenses; and

- the need to offset the variations in work flow while maintaining a consistent staffing level.

The HCFA proposal ignores the fundamental reason for the PIP program--to ensure adequate cash flow to hospitals when claims processing delays caused by fiscal intermediaries or changes in national policy are beyond the provider's control. HCFA believes that most providers on PIP will choose to convert to EMC. In addition, HCFA believes that potential hospital cash flow problems resulting from loss of PIP eligibility are minimal. We do not agree that providers who lose PIP because of non-conversion to EMC will experience minimal cash flow problems. As fiscal intermediaries are faced with increasingly tighter budgetary constraints and greater administrative responsibilities, and the Medicare program improves its own cash flow management, hospitals can expect to continue to experience delays in claims processing and longer payment cycles.

HCFA has previously attempted to institute minimum payment cycles for non-PIP claims of 15 days. Although this requirement was withdrawn before its actual implementation, it is our understanding that HCFA continues to informally instruct fiscal intermediaries to build up days of work on hand gradually and lengthen their current payment cycles deliberately, both for EMC and hard copy claims.

Medicare Data Reporting Burden

Over the past few years, hospitals have seen an increase in the level and amount of information to be reported to HCFA. Recent changes to the Medicare cost report have been on a piecemeal basis and are the result of legislative changes in payment methodology. Currently under discussion are proposed revisions to the cost report which include a session of "core reports" that can be filed by many community hospitals and a series of supplemental worksheets for hospitals that do not meet the filing criteria for the core reports. A major problem this year was a half year delay in releasing a revised cost report that severely affected both hospital and fiscal intermediary operations.

Although the content of the Medicare cost report has remained relatively consistent, the billing process and its data set have grown materially. Factors contributing to an aggregate increase in reporting burden include:

- the adoption of UB-82 (HCFA-1450) for inpatient and outpatient billing;
- the decision to report data for the PRO on the UB-82 billing form;
- an emphasis on identifying primary payer sources other than Medicare;
- the requirement to submit itemized laboratory charges on outpatient claims due to payment based on fee schedules; and
- the desire to gather additional information to further modify the prospective pricing rates.

Current hospital sentiment favors a reduction of the Medicare data reporting burden. With a move from cost-based payment to a fixed rate of payment for inpatient services, many providers support the elimination of various reported data on hospital inpatient costs. Other advocates of reporting modifications want to reduce the conflict between a prospective, market-oriented pricing methodology and payer access to detailed provider cost data.

The billing and cost report processes carry high costs of compliance that are borne by both hospitals and the Medicare program. From HCFA's perspective, there are costs of printing and distributing new forms and instructions, programming changes, and training programs. Often modifications are approached in a inadequate timeframe, which bears an added cost. For hospitals, the collection, retention, and reporting of data is costly, especially if it is superfluous to the task at hand. In addition, they, too, experience added costs for systems changes and training.

FISCAL INTERMEDIARY NOMINATIONS

Traditionally providers have had an option to designate the fiscal intermediaries from whom they will receive payments for covered services provided to Medicare beneficiaries. This nomination process provides a safeguard for hospitals by allowing them to choose intermediaries with whom they have or anticipate having a good working relationship. The nominated organization is approved if it meets various standards and criteria for administration of the Medicare program. The contractors are paid based primarily on reasonable costs.

The Deficit Reduction Amendments of 1984 authorized the Secretary to enter into a maximum of two agreements with fiscal intermediaries on the basis of competitive bidding. The arrangement is limited to replacing existing intermediaries that have performed in the lowest 20 percent of all intermediaries. HCFA is also permitted to award a fixed price or performance incentive contract on an experimental basis. Both of these arrangements replace the nomination process.

Already, HCFA has awarded a limited number of fixed price and competitive bid contracts to fiscal intermediaries for hospital services. In addition, HCFA has announced, through a notice of proposed rulemaking, that ten regional intermediaries will be designated for freestanding home health agencies. It is expected that hospital-based home health agencies may be brought into this program. As efforts to control program administration costs continue, HCFA is expected to engage in more regional contracting for all types of providers. In a 1984 study on intermediary nominations, the General Accounting Office (GAO) concluded that much of the inefficiency in contracting for Medicare claims processing and payment is a result of the intermediary nomination process. The GAO recommended that economies of scale be achieved through a reduction in the number of fiscal intermediaries, that incentive performance contracts be awarded, and that a single contractor be selected to handle both Part A and Part B in a particular area. Further study was recommended before abandoning the nomination process in lieu of competitive and fixed price contracting.

The proposed elimination of fiscal intermediary nomination and the substitution of a competitive bidding process pose many problems. First, the process of administering the Medicare program is extremely complex. Experience is important. Moving to a competitive bidding system could easily disrupt existing administrative systems, and provides little assurance that the new administrative entity will be capable of performing even at the level of the losing bidder. The experience of hospitals under competitively bid Medicaid contracts is not encouraging. In individual states there have been significant problems in timely processing of bills, resulting in substantial disruption of hospital operations. In a period of rapid change, it is even more important that the administrative entities have a high level of expertise, and well established channels of communication with providers. Moving to a competitively bid system would disrupt these channels of communication.

Finally, it should be noted that the PRO program relied on competitive bidding. Yet the PRO program has been plagued with difficulties in bringing the new organizations up to speed and in meeting performance objectives concerning the number of reviews to be performed and the timeliness of those reviews. Consequently, before throwing out a system that has evolved over twenty years, in exchange for an untried system, it is important to identify how best to build upon the strengths of the existing system.

PERFORMANCE STANDARDS

Because significant changes in administrative arrangements will be required if Medicare is to continue as a strong, efficiently operated program, it is important to have a clear sense of the administrative objectives of HCFA. The AHA has recently undertaken a comprehensive review of administrative arrangements, and has proposed several performance standards that should guide subsequent work. We urge Congress and HHS to give serious consideration to these standards as the restructuring of administrative arrangements is considered. These standards include:

1. The Value of the Information Collected The information collected should be valuable to the user(s) and it should be worth more than its cost to collect.

   Value is often expressed in monetary terms. From the hospital's standpoint, improvements in the billing process can lead to more accurate rate development. Value, however, is not figured solely in monetary terms. Value can also come in the form of better decision making, reduced risk, and better relationships between the contracting parties. Ideally, better billing data and more timely processing of bills would also provide hospitals and HCFA with better internal data, improving their relationships with each other and with Medicare beneficiaries.

   Cost in the billing process is a function of the amount of data collected and the number of steps through which the bill must be processed. The amount of data required dictates the procedures necessary to collect the data, the reporting vehicle necessary to capture the data, and the edit procedures necessary to insure the quality of the data. The more data that is collected, the greater the resources that are required by hospitals and HCFA to process it.

   Cost is a factor for all the participants in the billing process. In order for total value to be determined, the total value to all participants must be compared to the total costs of all participants.

However, because all parties are independent economic entities, the value of each of the parties must also be determined. If any one party is experiencing a negative cost/benefit relationship and is unable to adjust to its costs, then the negative impact on the party must be balanced by increased monetary consideration to that party before the procedure should be implemented.

2. The Entity Responsible for Performance It is essential in any process that personal responsibility be assigned for the individual tasks. The Medicare billing process is based on an interaction between the beneficiary, the provider, the fiscal intermediary, and HCFA. Each entity should have a defined set of procedures for whichit is responsible. Those procedures that the entity is responsible for must conform to the entity's ability to responsibly meet desired performance standards.

3. The Performance Standard of Each Entity The performance expected of and agreed to by each party must be known at the time the relationship is established or renegotiated. This is necessary so that each party can assess its risk and cost. It must be recognized that a failure to perform in the prescribed manner or a unilaterial change in the performance standards that apply to any one entity will change the risk assumed by the other parties. An incentive to induce responsible performance is to tie the level of payment that is received to a corresponding level of performance. Another incentive is the promise of a continue contractual relationship.

   Currently a hospital's principal incentive for efficient performance is the speed with which payment is received; the fiscal intermediary's incentives are the level of the contracted payments and a promise of continued contracting; and the beneficiary's incentive is the recapture of any funds that they appropriately should be reimbursed for. These all represent monetary incentives to the individual parties. HCFA has no real monetary incentive in the efficiency of the billing process other than reduced administrative costs. HCFA's principal incentive is performance related. HCFA must react to the perceptions of Congress and of Medicare beneficiaries to its management of the program. Given the current state of the billing and claims adjudication process, it is questionable whether this incentive is sufficient to prompt responsible behavior by HCFA.

4. Understandability Any process will be more efficient if it is easily understood by all the parties involved. The more the process can conform to a standard routine, the more easily that process is performed and the more the desired level of performance can be guaranteed. The current Medicare billing and claims adjudication process is based on an aggregation and expansion of HCFA's administrative and policy objectives as the program's payment formulas have evolved. They are complex and confusing to the extent that providers have a great deal of difficulty in following all the interrelated provisions and beneficiaries have only a very limited understanding. In order to make the program understandable, especially to the Medicare beneficiary, it will be necessary to make drastic changes in the complexity of the process.

5. Timeliness When dealing in financial terms, the timeliness of an action is an elusive, yet critical factor. Because all entities, including hospitals and the Medicare program, basically exist as cash-in/cash-out entities, it is important that a balance be maintained to ensure a sound financial position. If an acceptable cash-in/cash-out position can not be maintained from the operational resources of the entity, then outside sources of funds must be sought, operating costs increased and operations may be jeopardized.

6. Reports Should be Integrated If the information collected for the billing process is useful in other ways, then the value of each party is greatly increased. For example, if the Medicare billing data is also useful for internal management by the hospital and HCFA, then the billing process may substitute or support other efforts. In order for this to occur, the data and the collection vehicles should be integrated to permit cross referencing of the data and the objectives from other data systems.

CONCLUSION

The Medicare program is in a state of flux. New payment systems, new benefit designs, and new delivery arrangements are all serving to increase the complexity of the program, and all can substantially increase the uncertainty and confusion of patients, providers, and administrative agents. A concerted effort is required to hold this confusion to the minimum level, and commitment from the federal government is required to make sure that the resources needed to operate the program smoothly are available.

Chairman STARK. Thank you very much. Dr. Felts.

STATEMENT OF WILLIAM R. FELTS, M.D., CHAIRMAN, COUNCIL ON LEGISLATION, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY ROSS N. RUBIN, DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION

Dr. FELTS. Thank you, Mr. Chairman. I am a physician in the practice of rheumatology, here, in Washington, DC, as well as chairman of the council on legislation for the American Medical Association. With me today is Ross Rubin who is director of the association's department of legislation.

We have an increasing concern with carrier delays and strongly object to any position of the administration that delays and backlogs should be increased.

Delays in claims processing and payment have detrimental effects on both Medicare beneficiaries, and providers of services under the Medicare Program.

In effect delays shift cost from the Medicare Program to beneficiaries and providers. Beneficiaries are asked to wait longer for reimbursement of charges that they have paid.

When claims are assigned, nearly 70 percent of all claims are on an assigned basis, physicians are forced to suffer cash-flow operations that make it difficult to run a medical office.

Delays such as now are being experienced discourage acceptance of assignment on the very claims for which assignment may most benefit the beneficiary, and may force some physicians to reexamine the number of Medicare patients that they desire in their practice.

As recently as fiscal year 1983, Medicare carriers were paying claims in an average of 9.9 days. By December 1984, this turnaround time had grown to 12.3 days, and by June 1985 it was at 15.5 days.

It was at that time that OMB was urging the Health Care Financing Administration to increase the delay in claims processing to 30 days, in order to benefit from an extended float at beneficiaries and providers' expense.

This 100-percent delay was recommended, even though carriers could meet the shorter payment period. HCFA, at that time, properly rejected such an approach.

However, since then, the situation has deteriorated at a rapid rate. Several examples may be cited. By mid-March 1986, the average processing time for part B claims rose to 22½ days.

HCFA has projected that increases in the volume of claims, and cuts in the claims processing budget, will cause an average claim processing to increase to 34 to 37 days.

In Indiana it is taking at least 45 to 60 days for claims to be paid. In South Dakota, carrier turnaround time has increased from 11.7 days in March 1985 to 20.8 days in March 1986. In Georgia, the turnaround time has increased from 3 weeks to 8 to 10 weeks. HCFA arbitrarily ordered carriers to suspend payments of physicians' claims for services rendered beneficiaries on or after March 16, 1986.

While this was done ostensibly because no action had been taken on the fiscal year 1986 budget reconciliation bill, this delay was not authorized by law.

Even when a conference agreement was reached on March 20, which indicated that no changes in payment levels would take place before May 1, HCFA did not instruct carriers to resume processing until April 3, some 18 days later.

Certainly Presidential action was not a factor in the delay, since the order to resume processing took place 4 days before the President signed the bill.

At last week's hearing before this subcommittee concerning physician reimbursement, acting HCFA Administrator Desmaris, publicly announced, that claims processing for physician services would again be suspended on May 1 for 15 days to determine physicians' participation status.

On April 1, the HCFA Bureau of Program Operations issued directions to all Medicare part B carriers, indicating that carriers would be encouraged to increase their pending workload to 20 days' work on hand. In February 1986, the average was 13.4 days work on hand, up from 9.2 days work on hand in February 1985. The American Medical Association has consistently supported increased funding for carrier claims processing to avoid these problems we are now seeing.

Such support has stood in opposition to the administration budget requests that have consistently called for funding levels inadequate to meet the claims processing needs.

Mr. Chairman, while in the commercial world, it may be accepted business practice to delay on payment obligations, such a practice by the Federal Government under the Medicare Program is unacceptable.

When delays are deliberately instituted, such a practice is unconscionable. Payment delays cause substantial hardships for beneficiaries, as well as other undesirable results.

Delays certainly are counterproductive to Government attempts to encourage acceptance of the Medicare assignment. In addition, where assignment is not accepted, it is the beneficiary who must wait the additional time to be reimbursed.

We cannot condone, and strongly object to deliberate Medicare policies to delay payments. However, we can sympathize with HCFA as it attempts to cope with the continuous stream of major program modifications coming from the Congress. We urge the Congress to take such action as is necessary to assure prompt payment of claims under part B through adequate appropriations and other program modifications to improve claims processing.

That concludes our statement, Mr. Chairman. We will be pleased to answer any questions the subcommittee may have.

[The prepared statement follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

RE: Medicare Contractor Delays in Processing
Medicare Part B Claims

Presented by: William R. Felts, M.D.

April 22, 1986

Mr. Chairman and Members of the Subcommittee:

My name is William R. Felts, M.D. I am a physician in the practice of Rheumatology here in Washington, D.C. and serve as Chairman of the Council on Legislation of the American Medical Association. With me today is Ross N. Rubin, Director of the Association's Department of Federal Legislation.

The American Medical Association appreciates the invitation to testify today concerning delays in claims processing under Part B of the Medicare program. We have an increasing concern with carrier delays and strongly object to any position of the Administration that delays and backlogs should be increased. Delays in claims processing have detrimental effects on both Medicare beneficiaries and providers of services under the Medicare program and are leading to increased frustration with the program's inefficiencies. Most beneficiaries and providers only learn about such delays through experience--they don't get paid in a timely manner. There is little or no communication with beneficiaries or providers concerning the existence or reasons for delays. This compounds problems at the carrier level when the phone contacts are necessary to determine the status of long outstanding claims or when claims are resubmitted on the assumption that they may have been lost or misplaced. The lack of carrier phone service itself only adds to the frustration.

In effect, delays shift cost from the Medicare program to beneficiaries and providers. Beneficiaries are asked to wait longer for reimbursement of charges that they have paid. When claims are assigned (nearly 70% of all claims are on an assigned basis), physicians are forced to suffer cash flow interruptions that make it difficult to run a medical office. Staff must be paid, supplies must be purchased, rent comes due, malpractice premiums cannot be delayed, and taxes must be paid regardless of whether Medicare processes claims on a timely basis or not. Of special concern is the fact that, as the size of a claim goes up, the rate of assignment increases. Therefore, delays in claims processing discourages assignment on the very claims for which assignment may most benefit the beneficiaries and may force some physicians to re-examine the number of Medicare patients in their practice.

As recently as fiscal year 1983, Medicare carriers were paying claims in an average of 9.9 days. By December 1984, this turn-around time had grown to 12.3 days, and by June 1985 the delay was 15.5 days. It was at that time that the Office of Management and Budget (OMB) was urging the Health Care Financing Administration (HCFA) to increase the delay in claims processing to 30 days in order to benefit from an extended float at beneficiaries' and providers' expense. This 100% delay was recommended even though carriers could meet the shorter payment period. HCFA, at that time properly rejected such an approach. However, since that time the situation has deteriorated at a rapid rate.

- By mid-March 1986 the average processing time for Part B claims rose to 22.5 days. This was for so-called "clean" claims and does not include claims where there was need for some inquiry. Since this is an average, some carriers were above this level.
- HCFA has projected that increases in volume of claims and cuts in claims processing budget will cause average claim processing to increase to 34-37 days. In Indiana it is taking at least 45-60 days for claims to be paid. In South Dakota carrier turn-around time has increased from 11.7 days in March of 1985 to 20.8 days in March of 1986.
- We have been informed by the medical society in Georgia that the turn-around time in that state has increased from three weeks to eight-ten weeks.
- The number of Part B claims in carrier ending inventory has grown dramatically from a level of 10.7 million claims in 1985 to 15.1 million claims in February 1986.
- Claims pending over 30 days have also increased from 1.08 million in October 1984 to just under 2 million in February 1986.
- HCFA arbitrarily ordered carriers to suspend payment of physician claims for services rendered beneficiaries on or after March 16, 1986. While this was done ostensibly because no action had been taken on the FY86 Budget Reconciliation bill (H.R. 3128), this delay was not authorized by law. Even when a conference agreement was reached on March 20, which indicated that no changes in payment levels would take place before May 1, HCFA did not instruct carriers to resume processing until April 3. Certainly Presidential action was not a factor in the delay, since the order to begin processing took place four days before the President signed the bill on April 7.
- At last week's hearing before this Subcommittee concerning physician reimbursement, acting HCFA Administrator Desmarais publicly announced that claims processing for physicians' services would again by suspended on May 1 for fifteen days to determine physicians' participation status. Procedures should be instituted to assure that such a delay is not repeated by arranging for the sign up period to end prior to the date updates are allowed.
- On April 1 the HCFA Bureau of Program Operations issued directions to all Medicare Part B carriers indicating that carriers would be "encouraged" to increase their pending workload to 20 days work-on-hand. In February 1986 the average was 13.4 days work-on-hand, up from 9.2 days work-on-hand in February 1985.

The AMA has consistently supported increased funding for carrier claims processing to avoid the problems that we are now seeing. Such support has stood in opposition to Administration budget requests that have consistently called for funding levels inadequate to meet claims processing needs.

Mr. Chairman, while in the commercial world it may be accepted business practice to delay on payment obligations, such a practice by the federal government under the Medicare program is unacceptable. When delays are deliberately instituted, such practice is unconscionable. Payment delays cause substantial hardships for beneficiaries as well as other undesirable results. Delays certainly are counter-productive to government attempts to encourage acceptance of Medicare assignment. At a time when physicians are being urged to take their claims on an assigned basis and to be "participating physicians," the federal government is causing increasing delays in turn-around time between submission of claims and payment. This slowing of payment rate is a substantial disincentive for acceptance of assignment. Deliberate delays make a mockery of even the so-called participation "incentives." In addition, where assignment is not accepted, it is the beneficiary who must wait the additional time to be reimbursed.

We cannot condone, and strongly object to deliberate Medicare policies to delay payments at the expense of Medicare beneficiaries and providers of services under the Medicare program. However, we can sympathize with HCFA as it attempts to cope with the continuous stream of major program modifications coming from the Congress which require unprogrammed recalibration of profiles, delays in updates, monitoring of participation status, and many other new initiatives while having to deal with budget reductions and funding cuts such as Gramm-Rudman. We urge the Congress to take such action as necessary to assure prompt payment of claims under Part B of the Medicare program through adequate appropriations and other program modifications to improve claims processing.

Mr. Chairman, we would be pleased to answer any questions the Subcommittee may have.

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Chairman **Stark**. Thank you, Doctor. Mr. Kovener.

STATEMENT OF RONALD R. KOVENER, VICE PRESIDENT, HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

Mr. **Kovener**. Thank you. I am with the Healthcare Financial Management Association—not to be confused with HCFA.

Our over 25,000 members, all across the country, are the individuals that process these bills, and they are the ones that worry about the cash-flow in our Nation's hospitals.

There have been numerous changes in the fiscal intermediary responsibilities, activities, and incentives in recent years. Some of these changes have created huge backlogs in bills, and delays in processing.

Reduced intermediary funding has shifted processing burden from the intermediaries to hospital business offices. The Health Care Financing Administration has now, as you know, decided to process bills even more slowly.

HCFA contracts with intermediaries have added complexities in the processing of bills, once contract terms have been set. The intermediaries have found that they have to cut corners in ways that they did not anticipate when the contract was accepted.

Many intermediaries have found it necessary to reduce the verification of claims received, so that minor clerical entry errors require followup investigation by the fiscal intermediary, and especially by the provider, resulting in additional processing delay, and additional cost, especially to the providers.

HCFA has given the processing of claims a very low priority in the array of things that intermediaries are supposed to do.

The Federal Government has significant incentives to delay payments, since the Government does not follow generally accepted accrual accounting practices. Even though the Government has incurred an obligation, if it does not process the payment, the Government ignores the fiscal impact of the obligation that has been incurred.

Fiscal intermediaries are trying hard, we believe, to fulfill the expectations of providers, as well as the Government, and are put in an ever-tightening squeeze. The funding for intermediary activities must be commensurate with the scope of activities they are called upon to provide. There must be additional compensation if additional or changed activities are required.

Medicare's current prospective price-setting system evolved from the former cost-based system. The old system did not include working capital as a cost, because initially, payment to providers was simultaneous with the provision of service. Current Medicare payment rates are based on that historic precedent, that Medicare payment is to be prompt——

Chairman **Stark**. Did we not always take working capital into account on payment for capital?

Mr. **Kovener**. At the initial time of Medicare, there were things like current financing, emergency financing, and other things that were done, so that the payment was simultaneous with the provision of service.

Chairman **Stark**. The working capital was not part of the——

Mr. Kovener. And there was no working capital built into the program in any way.

Chairman Stark. When did they start to pay a return on capital?

Mr. Kovener. Return on equity is paid to investor owned hospitals only.

Chairman Stark. Return on equity. I understand that. But we also pay a capital on the——

Mr. Kovener. You pay on plant capital—interest, and depreciation.

Chairman Stark. And not on working capital?

Mr. Kovener. Not on working capital.

If payment arrangements are to be changed or lengthened as is being done, it is essential that hospitals be compensated for this working capital factor.

Continued processing of payments to providers, using the periodic interim payment method is a cost-effective way of minimizing the processing cost for intermediaries and the Government. It provides a dependable flow of funds to hospitals. All parties benefit from this system and it should be retained.

Interest for delayed Medicare payment seems desirable, but keep in mind that hospitals are different from other government providers. The normal vendor relationship is not analogous to the relationship that Medicare has with providers, largely because Medicare payment rates do not include a factor for working capital.

Interest on payments delayed more than 30 days assumes that a 30-day working capital provision is built into the price. These circumstances are not relevant to hospitals and interest on late payments will be helpful, but Medicare rates must be adjusted for the working capital factor, even in these circumstances.

Industry data shows a significant decline in hospital liquidity. Our data shows that the average time that elapses before hospitals can pay their liabilities has reached over 54 days in 1984. This lag time has been steadily increasing since 1978 and increased by a larger than normal percentage in 1984. This trend evidences liquidity problems. These problems result from delays in collections from Medicare and other payers, as reflected in another liquidity measure called "Days Revenue, in Accounts Receivable." This ratio took a sharp turnup of almost 3 days in 1984, to a median of over 64.3 days—in other words, the time between when services are rendered, and the time when the money comes in the door to pay for those services.

Our service does not measure payment delays for individual payers, but we have been told by many of our members, recently, that Medicare is now one of the slowest payers of any of the organizations to whom health care services are sold.

The intermediary role includes many components. We favor prompt, efficient processing of each of those components. We agree that there are opportunities for HCFA to simplify their requirements, but many of the complexities that are built into the intermediary system are in response to efforts, and demands, largely from Congress, that the system approach perfection.

These are distinct dangers to fragmentation of the intermediary role. Intermediary payment must be commensurate with the duties assigned. There is good evidence that this is currently not the case.

The Government has a duty to pay promptly. The already existing difficulty and deficiency in payment must be recognized. Interest for late payment would help quantify the extent of late payment problems but is not a basic solution.

Payment of 85 percent of claims in 30 days is not a reasonable payment schedule.

The current PIP system seems to be misunderstood, generally, but it is equivalent to payment of a claim on an individual basis, serves the best interest of all parties, and should be retained.

That completes my testimony.

[The prepared statement follows:]

STATEMENT OF THE HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION (HFMA)

SUMMARY

There have been numerous changes in fiscal intermediary responsibilities, activities, and incentives in recent years, many of which have resulted in a slowdown in processing payments.

Recently, fiscal intermediaries have been instructed to delay the period of time between receipt of claims and the processing of payment.

The funding for intermediary activities must be commensurate with the scope of activities they are called upon to provide.

Payment practices under the former cost-based system are relevant to current Medicare payment rates. At the origin of Medicare, payment was simultaneous with provision of services.

Processing of payments to providers using the periodic interim payment method is a cost-effective way of minimizing the processing costs for intermediaries and the government and provides a dependable flow of funds to hospitals. Thereby, all parties benefit and this system should be retained.

Relations between government and its other regular analogous to the relationship that Medicare has with providers. The prompt payment act provisions should not be applied to Medicare payments unless rates are adjusted for working capital.

Industry data shows a significant decline in measures of liquidity. Medicare is now one of the slowest payers of any of the organizations to whom healthcare services are sold.

Profit margins do not allow hospitals to absorb deficiencies in payment arrangements. Since Medicare is the largest single purchaser, it has a special responsibility to pay promptly.

ABOUT HFMA

I am Ronald R. Kovener, Vice President of the Healthcare Financial Management Association (HFMA). HFMA is a professional membership association composed of over 25,000 individuals in 74 chapters who share an interest in financial management of hospitals and other healthcare institutions. HFMA's members include representatives from all major types of hospitals; urban and rural, large and small, investor-owned and tax-exempt, teaching and nonteaching, freestanding and multiple facility. In addition, our membership includes public accountants, financial consultants, and investment bankers, as well as representatives of Blue Cross, commercial insurors, and others who pay for healthcare services.

CURRENT FISCAL INTERMEDIARY OPERATING REALITIES

There have been numerous changes in fiscal intermediary responsibilities, activities, and incentives in recent years. Some payment processing changes by Medicare include:

Change to fee schedules for outpatient laboratory services that caused extensive confusion, huge backlogs of bills, and multiple submissions of information.

Reduced intermediary funding that has resulted in a curtailing of verification of input data with resultant errors and processing delays.

Additional requirements for billing, including medical record coding and physician attestation and ever-changing intermediary instructions concerning bill information requirements.

Strong indications to intermediaries from the Health Care Financing Administration that they should process bills more slowly.

PRO review of outliner cases that causes delay in processing.

Intermediary difficulties in assigning DRGs that require additional follow-up and verification by providers.

Elimination of the Medicare Report of Eligibility that has caused confusion among intermediaries and beneficiaries and has slowed payment from insurors with secondary responsibility.

Let me elaborate on a few of these changes. The Notice of Admissions and Report of Eligibility have recently been eliminated. This has required extensive changes in systems and has resulted in the slowdown in processing of payments. This change has also resulted in the introduction of much uncertainty for providers and fiscal intermediaries concerning the status of claims, further slowing their processing.

Another significant change in intermediary operations was required when the method of payment for outpatient lab services was changed. The relationship between Part B claims and Part A claims was also changed. These changes were decided upon with inadequate notice to intermediaries. As a result, many claims had to be processed more than once and a significant backlog resulted.

In order to get the best price for fiscal intermediary activities, HCFA has established fixed rate contracts. Added complexities in processing bills, once a fixed-rate has been set, have forced intermediaries to cut corners in ways that they did not anticipate when the contract was accepted. For example, many intermediaries have been forced to reduce the verification of claims received, with the result that claims with minor clerical entry errors enter the system, do not compare favorable with the norms and thresholds established by the fiscal intermediaries, and thereby require follow-up investigation by the fiscal intermediaries and the provider. Thus, much additional processing and delay results from inadequate initial verification.

HCFA has established priorities for the activities of intermediaries. Processing of claims is an activity with a very low priority. Of course, to providers this is the most important activity that the intermediary carries. Smooth functioning of this activity is esesntial to the regular flow of funds from Medicare to providers.

Recently, fiscal intermediaries have been instructed to further delay the period of time between receipt of claims and the processing of payment. This is part of a long pattern of such delays in processing payments, as well as extension of time for PIP payments. The federal government has significant incentive to delay payment since the government does not follow generally accepted accrual accounting practices. Accordingly, even though the government has incurred an obligation, if it has not processed the payment, the government ignores the fiscal impact of the obligation that has been incurred.

Fiscal intermediaries are trying hard to fulfill the expectations of providers, as well as the government and are put in an every-tightening squeeze. The funding for intermediary activities must be commensurate with the scope of activities they are called upon to provide. There must be additional compensation if additional or changed activities are required and the intermediary should be able to follow good business practices in processing claims to providers in a prompt manner.

AN HISTORIC PERSPECTIVE OF CURRENT MEDICARE PAYMENT ARRANGEMENTS

Current Medicare payment rates are based upon the cost experience of hospitals prior to the origination of the prospective price setting (PPS) system. Accordingly, the payment practices under the former cost-based system are relevant to current Medicare payment rates.

At the origin of Medicare's cost-based payment arrangements, payments were calculated without any recognition of working capital. Working capital is the amount of money that any business must have to compensate for the a lag between the time the hospital must pay its vendors and employees and when it receives payment for services. Working capital must increase as prices increase or as the time lag lengthens. It is also necessary that the time cost of money invested in working capital be recognized. The necessity that working capital be included in prices is common to every business including hospitals.

At the origin of Medicare, consideration of working capital was excluded because Medicare adopted payment arrangements that resulted in a flow of funds to providers that was simultaneous with provision of services. In the early days of Medicare, there were provisions known as "current financing" and "emergency financing" which actually gave the hospital money equal to the working capital investment that the hospital was required to make. These provisions were overlaid by improved Medicare claims processing capabilities and the initiation of an arrangement known as "periodic interim payments" (PIP). Under this arrangement, total annual payments to the hospital are estimated and regular payments, every two weeks, toward this obligation are made. This regular flow of funds is equal to the eventual Medicare obligation to the hospital. The flow of funds is approximately equal to that which would occur if payment were based on each claims processed. This system saves the fiscal intermediaries a substantial amount of time and effort in matching individual claims on a current basis with the payments made to the hospitals.

Current Medicare payment rates are based on the historic precedent that payment is made promptly. If payment arrangements are to be changed, it is essential that hospitals be compensated for this change by recognizing that working capital is necessary. Payment rates must include this cost element, and the time cost of money that is also involved must be added. Continued processing of payments to providers using the periodic interim payment method is a cost-effective way of minimizing the processing costs for intermediaries and the government and provides a dependable flow of funds to hospitals. Thereby, all parties benefit and this system should be retained.

HOSPITALS ARE DIFFERENT FROM OTHER GOVERNMENT VENDORS

There is a governmental provision known as the "prompt payment act" which requires payment to vendors within 30 days and requires an interest payment if vendors are not paid within a 45-day period. This is consistent with normal business practices in which prompt payment is generally recognized by vendors in the form of a prompt payment discount, a discount for cash, or some other recognition of the difference in cost that is inherent in an extended payment arrangement.

The normal purchasing/vendor relationship is not, however, analogous to the relationship that Medicare has with providers. Medicare payment rates, as noted above, do not include a factor for working capital. The prompt payment act obviously assumes that a 30-day working capital provision is built into the vendors' price and recognizes the time value of money for extreme delays. These circumstances are not relevant to hospitals and the prompt payment act provisions should be applied to Medicare only after rates are adjusted for working capital as described previously.

LIQUIDITY MEASURES

Industry data shows a significant decline in measures of liquidity. Liquidity measures tracked by HFMA's Financial Analysis Service (FAS)[1] include the promptness of payment of liabilities and the promptness of collection of receivables. HFMA's FAS shows that the average time that elapses before liabilities are paid reached over 54 days in 1984 with a quarter of subscriber hospitals taking 67 days or longer. This lag time has been steadily increasing since 1978 and increased by a larger than normal percentage in 1984. This trend evidences liquidity problems. These problems result from delays in collection from Medicare and other payers as reflected in days revenue in accounts receivable. This ratio took a sharp turn up of almost three days in 1984 to a median of over 64.3 days. FAS does not measure payment delay for various payers, but we have been told by some of our members recently that Medicare is now one of the slowest payers of any of the organizations to whom healthcare services are sold.

COPING WITH PAYMENT SLOWDOWN

An adequate flow of cash to pay for salaries, food, heat, etc., is as essential to hospitals just as it is any business. Normally, a business meets its working capital requirements through its prices. Hospitals do not set their prices to Medicare, however. These prices are imposed by the program.

Profits took a temporary upturn at the start of the PPS program, but are still very meager. In 1984, the median hospital had an operating margin of just 3.1 percent. If this margin were price-level adjusted, the median hospital actually suffered a 1/10 percent loss. Thus, the profit margins, even in the relatively good year of 1984, do not allow hospitals to absorb deficiencies in payment arrangements.

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[1] HFMA's Financial Analysis Service (FAS) is based on audited financial reports (not Medicare cost reports or coded data provided by hospitals). As a result, the data is extremely reliable. All coding is done centrally to improve unformity. Comparability and consistency is much better than with unaudited data. The data may not be representative of the hospital industry as a whole and we believe subscribers tend to be more financially healthy than average. In total, data from 6,796 hospital years is included in the most recent five year report of FAS data.

The ability to generate a profit is being further reduced by regulatory and legislative changes, such as freezes in rates or meager increases, cutbacks in medical education payments, and a host of other payment changes. Therefore, hospitals continued ability to provide services to Medicare beneficiaries and their ability to serve the healthcare needs for the entire population of their communities depends upon an adequate cash flow from all purchasers. Since Medicare is the largest single purchaser it has a special responsibility to pay promptly.

CONCLUSION

To summarize HFMA's views, I would again stress the following points:

Numerous changes in fiscal intermediary responsibilities, activities, and incentives in recent years has resulted in a slowdown of claims processing. There is evidence that intermediaries will be required to slow claims processing further. In order to avoid these slowdowns, funding for fiscal intermediary activities must be commensurate with the scope of activities they are required to provide. All businesses require a dependable flow of funds for working capital. In most businesses, this is included in the price. PPS prices include no such provisions. Therefore, it is vital that current payment lag not be increased and the PIP be continued in the absence of adjusting prices for such costs. Because PPS prices don't include working capital, the provisions of the prompt payment act are not applicable.

This completes my testimony. I will be happy to answer any questions the subcommittee may have.

[The following was subsequently received:]

Healthcare Financial Management Association,
Washington, DC, May 7, 1986.

Hon. Pete Stark,
Chairman, House Ways and Means Subcommittee on Health,
Longworth House Office Building, Washington, DC.

Dear Mr. Stark: The attached letter was received on the day I was providing testimony to your subcommittee concerning the problems of cash flow experienced by our nation's hospitals. I would like to attach this letter to the testimony we provided to your subcommittee and am forwarding a copy of the letter to all of the members of your subcommittee. Mr. Campbell's letter personifies the frustration that all of our members are feeling so acutely.

Sincerely,

R.R. Kovener, *Vice President.*

Johnson County Regional Hospital,
Clarksville, AR, April 3, 1986.

Ronald Kovener,
Vice President, Financial Analysis Services, HFMA,
Oak Brook, IL.

Dear Mr. Kovener: Attached is a memo that I received, today, from Arkansas Blue Cross acting as the Medicare Intermediary. This humble little memo informs us, in the second paragraph, that they will be withholding all payment for care rendered to all Medicare patients that we have served, in good faith, since the 15th of March.

That the government can unilaterally breech their agreement and so harm the reasonable men and women who work in our hospitals, by depriving us of as much as two thirds of our total billing is profoundly abominable.

The memo itself was informationally inadequate and incomplete and, the phone number in the last sentence could not be reached. The inept and uncaring bureaucrats should not have such broad power so far removed from the intent of our good lawmakers and our Constitution.

I am calling on you today, to courageously work to ensure that our modest but fine hospital is not so financially violated again. On behalf of my colleagues and for our hundreds of thousands of Medicare patients (living on a thread of unkept promises), I thank you for your continued helpfulness in this regard.

Sincerely,

Jerry Campbell, *Executive Director.*

Chairman **Stark**. Thank you. Mr. Ecker, you suggest that a lot of small hospitals cannot adopt their data processing systems to submit their claims electronically.

What is required for a hospital to submit their claims electronically?

Mr. **Ecker**. We have two concerns, Mr. Chairman. One is, there are a number of small hospitals that do not have data processing capability at all.

Chairman **Stark**. Yes; but they have telephones.

Mr. **Ecker**. Yes, sir, but in terms of terminals, they may not have that capability.

Chairman **Stark**. Yes; but what does a terminal cost? I mean, that is not because of cost; it is just because they cannot figure out how to work them.

Mr. **Ecker**. No; it largely, in the past, has been a cost consideration to go with the necessary software that would accompany the hardware.

Chairman **Stark**. OK. But if the intermediary provided the software and installed the terminal——

Mr. **Ecker**. That would be fine.

Chairman **Stark**. Yes; that would be pretty simple, would it not?

Mr. **Ecker**. Yes.

Chairman **Stark**. And not very expensive?

Mr. **Ecker**. Probably not. The second concern is that when they make changes in the software—and again, depending on whether the hospital is required to make the changes, or whether it is provided to them—it is time-consuming and frequently expensive in order to make the necessary changes in the software so that it is compatible with the intermediary requirements.

Chairman **Stark**. And I would assume, Dr. Felts, that for physicians, whether or not they submit their claims through electronic media, is just a question of whether or not there are enough claims to justify paying for the terminal?

If we got to some kind of a standardized submission software, then it is just up to the individual physician's office manager, or recordkeeper, as to whether it was quicker to type it up and put it in the mail, or put it on a terminal and submit it.

There is no real problem, other than that, is there——

Dr. **Felts**. Oh, there are problems other than that, because it is a complicated process, in addition to the hardware, which is probably the least expensive part of the problem.

There is a matter of compatible software, and its acquisition and maintenance, and the maintenance factor is a significant one, to try to keep in tandem with the directives as they come down, and the differing requirements by different insurance firms. And then there is a training cost that goes into training personnel to use the system, and this is an ongoing problem.

Chairman **Stark**. Doctor, you know, I figure that any time I come into your office, somebody who can run all those machines that you wire me up to sure as hell ought to be able to figure out an Apple computer.

Dr. **Felts**. It is possible.

Chairman **Stark**. If they cannot, I am in trouble.

Dr. **Felts**. It is possible, sir, but it does have a significant cost attached to it.

Mr. **Rubin**. Mr. Chairman, we would also point out that it took 15 years to get a universal claim form agreed to. It took 10 years for us to sell a unique procedural terminology, maybe because the AMA was advocating it, it was looked at in a jaundiced way, but it took an awful lot of time and effort just to get those steps. Those steps would make it easier for electronic media.

Let me say that a lot of the carriers do not have a capability to accept electronic claims from all the physicians, and they are increasing that capacity; but if they are not receiving enough money to do that, then of course that will delay the implementation and expansion.

Chairman **Stark**. Thank you. Mr. Daub.

Mr. **Daub**. I do not think I have any questions of this panel. We appreciate your helping us to have a good record of the points of view of members. This is a subject that I am sure the chairman, and all of us on the committee are going to pursue. We appreciate, again, your taking time to be with us.

Chairman **Stark**. The staff may have some questions that we would like to have you respond to, in writing, for the record, and I appreciate your patience and cooperation with the committee.

The subcommittee stands adjourned.

[Whereupon, at 12:28 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF

THE AMERICAN ASSOCIATION OF RETIRED PERSONS

The American Association of Retired Persons (AARP), representing 22 million persons age 50 and above, is pleased to submit this statement on Medicare claims processing for the record to the Ways and Means Subcommittee on Health. AARP urges that Congress direct the Health Care Financing Administration (HCFA) to implement policies which create an efficient claims processing system. An essential element to the success of any program is the degree of confidence held by those who use and are served by the program. Efficient claims processing is key to the degree of confidence held by beneficiaries and health care providers because claims processing is one of the most direct ways in which beneficiaries and providers determine the success and effacacy of Medicare. An efficient system is essential in preventing delays in payment, reducing the rate of payment errors, and providing quality service to health care providers and beneficiaries. In order to create such a system, AARP urges adequate funding for contractors and use of current HCFA authority to remove poorly performing contractors from the Medicare program.

AARP has received hundreds of letters from our members complaining about the performance of Medicare fiscal intermediaries. Complaints have focused on carrier telephone toll-free 800 numbers so busy that they cannot obtain answers to their questions about Medicare payment; and delays in processing claims of often 3 or 4 months and sometimes even longer.

Another frequent complaint is the inability to obtain a statement from the contractor stating the amount of Medicare's payment to the provider. Without this statement, beneficiaries cannot file for claims with their supplemental insurance carriers.

A cost-effective and efficient system is an obtainable goal. Prompt payment is an essential mechanism for achieving such a goal. Delays have already grown from 10.8 days in March 1983 to 13.9 days in March 1985. These delays can be expected to increase because contractor funding for claims processing is decreasing at a time when the volume of claims and regulatory and legislative changes are increasing.

Delays in the processing of claims creates a powerful disincentive for physicians to accept Medicare assignment, due to uncertainty about their Medicare cash-flow. If assignment decreases, beneficiaries will face even larger out-of-pocket expenses for physicians' care. Recent gains in the number of participating physicians and assignment rate are encouraging. Policy should build upon these efforts, not discourage it.

In addition, long delays in claims processing, whatever the cause, disadvantage the beneficiary directly. Many beneficiaries pay the physician charge and then wait for reimbursement. Long delays prevent beneficiaries receiving needed reimbursement for paying their medical bills, even if they have supplemental insurance since beneficiaries are required to submit a statement of Medicare reimbursement to their supplemental insurance carrier.

AARP agrees with the findings of the General Acconting Office report entitled "Medicare Contracting: Existing Authority Can Provide for Effective Program Administration."

In particular we would like to stress the GAO recommendation that adequate funding is necessary for an efficient claims processing system. AARP has long argued that the prerequisite to an efficient system is proper contractor funding. In fiscal year 1986, virtually no growth in funding was permitted (due to Gramm-Rudman sequestation) while carriers coped with an increasing volume of claims, and an increase in the number and complexity of regulations and laws. Adequate funding will ensure timely payments and safeguards against costly and inappropriate payments. Limiting contractor budgets may save money in the short term. However, in the long term, costs to Medicare, providers and beneficiaries increase because of the growth in payment error rate.

Secondly, AARP supports the GAO report's findings that existing authority is sufficient to remove poorly performing contractors from the Medicare program. We urge Congress to ensure that HCFA use this authority in order to maintain quality service in the future.

AARP urges caution about changing from cost-contracts to competitive bidding for contractors. The GAO report clearly identifies several causes for concern in regard to the competitive approach. Competitive bidding may save funds initially but there is no guarantee that this will occur with each re-competition. Also, the GAO clearly demonstrates that when changing from one contractor to another, HCFA needs to closely monitor the transitional phase. This monitoring is necessary to ensure delays do not occur and that correct payment is made. Disruption in service and confusion brought about by a new contractor implementing complex regulations will not provide quality service to beneficiaries or providers. This monitoring may use more of HCFA's resources than necessary under cost contracts.

As you study the problems of Medicare contracting, AARP urges you to maintain a clear and consistent policy to encourage timely processing of Medicare claims and to build upon current physician incentives to participate and accept Medicare assignment.

John Rother
Director, Division of
Legislation. Research &
Public Policy

BEST COPY AVAILABLE

STATEMENT ON MEDICARE CONTRACTING
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

April 22, 1986

The American Health Care Association (AHCA), representing approximately 9,000 nursing homes and allied health care providers, appreciates this opportunity to submit testimony on Medicare contracting issues.

AHCA is aware of and supports the need for effective controls on public expenditures, including administrative costs in the Medicare program.

However, we are concerned that some of the approaches being taken may not be the most efficient or effective methods of cost control and that, further, the burden of the methods selected may fall most heavily on small Medicare providers and on beneficiaries.

As you are undoubtedly aware, Congress most recently recognized the need to improve beneficiary access to Medicare long term care services by encouraging skilled nursing facility participation in Medicare when it included Sec. 9126 of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), which permits a simplified payment mechanism for small (fewer than 1,500 Medicare patient days per year) providers.

The Health Care Financing Administration instructions that claim backlogs be allowed to grow will have an opposite effect, discouraging this small provider from program participation. Our experience and intermediary data indicate that the claims of facilities that cannot submit claims electronically or cannot avail themselves of the periodic-interim-payment method of payment are already processed more slowly than the majority of Part A claims. Intermediaries predict that the slowed down claims processing will have proportionately greater effect on these claims. This will, of course, detrimentally affect the cash flow of the very facilities that have fewer excess resources upon which to draw. This will tend to discourage their participation, negating the intent of Sec. 9126 and resulting in continuing lack of access to Medicare long term care services for beneficiaries in areas that have a limited or nonexistent supply of such services.

We understand that many intermediaries have indicated to HCFA that they can achieve cost savings comparable to those projected by delaying claims processing without resorting to this counterproductive approach. We believe they should be given this opportunity.

We are also concerned that contractor performance evaluation and contractor selection methods have and will continue to focus too heavily upon obvious but often illusory cost savings that ignore the quality of service to beneficiaries and providers. We have seen too many occasions when changes in intermediaries and carriers or extreme emphasis on cost savings have resulted in delayed claims processing, arbitrary and erroneous changes in interpretation of rules and improper denials of benefits for both Part A and Part B claims. We therefore recommend that Congress take steps to assure that necessary cost-saving changes in the administration of the Medicare program are designed so as to have the least detrimental effect possible upon beneficiary access to to Medicare services.

STATEMENT OF THE
AMERICAN HEALTHCARE INSTITUTE

The American Healthcare Institute on behalf of the 35 not-for-profit, multi-hospital systems that it represents appreciates the fact that the Subcommittee on Health of the Ways and Means Committee conducted hearings on the important subject of administration of the Medicare program. Both the Congress and the Administration have moved aggressively in the past several years to both reduce the level of funding for the administration of the Medicare program at the same time that major new program initiatives have been implemented. It is important that we take the time to consider the consequences of the interaction of these seemingly disparate actions.

Since 1981, each year has seen a major legislative initiative containing major changes in the Medicare reimbursement systems. We have, since 1981, initiated a uniform Part A billing form for hospitals, the prospective payment system, a physician fee freeze and a participation program, new laboratory fee schedule, changes in other Part B reimbursement, as well as major changes making Medicare a secondary payer under certain circumstances. The Blue Cross and Blue Shield Association estimates that in this period there have been 50 fundamental policy changes in the Medicare program which includes over 800 specific items requiring administrative action. This year alone there were 51 separate provisions requiring implementation in the Consolidated Omnibus Budget Reconciliation Act (COBRA).

The fact that the Medicare contracting community has been able to respond on a timely and accurate basis to these changes over the last five years is a statement to the dedication and skill of their employees. We however are concerned that we have reached the point at which dedication and skill can no longer offset what is clearly an inadequate funding level. Contractor resources continue to be reduced on a per claim basis each year. Since 1978 the per claim reimbursement for Part A intermediaries has been reduced by 51% and the corresponding reduction for Part B carriers has been 38%. Further refinements to the Medicare program involving major administrative changes will simply not be possible given the current level of funding.

THE AMERICAN HEALTHCARE INSTITUTE STRONGLY RECOMMENDS THAT THE WAYS AND MEANS COMMITTEE PROVIDE, AT THE TIME OF ENACTMENT, THE REQUISITE ADMINISTRATIVE FUNDS NECESSARY TO IMPLEMENT LEGISLATIVE CHANGES ON A TIMELY, EQUITABLE BASIS.

As a result of the Gramm/Rudman sequestering order for fiscal year 1986, the Health Care Financing Administration reduced the funds available to the Medicare contractors and subsequently instructed them to slow down the processing of Medicare claims. The potential for additional sequestering actions to occur for the fiscal year 1987 budget remains high. In light of this potential we believe it is important that everyone be aware of the current circumstances regarding Medicare claims processing. According to the calculations performed by the American Healthcare Institute the weighted average of the time for processing of Part A claims is 14.987 days. In addition, we believe the average check writing cycle to be approximately 7 days. This means that at the current level of performance the average Medicare Part A claim takes 22 days to process. Claims for home health care and skilled nursing facilities already take on average over 30 days for processing.

It is clearly undesirable from both the program management and the provider point of view that the average claims payment time to exceed the standard of 30 days. Since we are already close to that standard for all Part A business and over that standard for certain parts of Part A, THE AMERICAN HEALTHCARE INSTITUTE STRONGLY BELIEVES THAT THE BUDGET DIFFICULTIES ENCOUNTERED BY THE CONTRACTORS BE ACCOMMODATED BY METHODS OTHER THAN SLOWING THE PROCESSING OF CLAIMS. There are other items that can in fact be implemented and we hope that the committee will agressively point these out to the Administration. Focusing efforts on inefficient contractors and reducing their costs is but one step that should be taken rather than a uniform delay in claim payment. We strongly urge the committee to examine these and other methods for providing adequate contractor funding.

STATEMENT OF
JAY GOODFARB, PRESIDENT
OF THE
PRIVATE PRACTICE SECTION
AMERICAN PHYSICAL THERAPY ASSOCIATION

As President of the Private Practice Section of the American Physical Therapy Association ("APTA"), I submit this statement in response to the request of the Subcommittee on Health, House Committee on Ways and Means, for written testimony on Medicare contracting issues. In particular, Private Practice Section comments will address problems experienced by providers of outpatient physical therapy as a result of growing Medicare claims backlogs.

The Private Practice Section of the APTA is a professional organization and a special interest component of the APTA, with over thirty years experience in meeting the needs of physical therapists in private practice and their patients. Members reside in all 50 states, the District of Columbia, Guam and the Virgin Islands. Currently, some 2,804 physical therapists are members of the Private Practice Section.

The purpose and functions of the Private Practice Section include:

- providing opportunities for members to consider mutual areas of professional interest;
- promoting standards of physical therapy services provided by physical therapists in the private practice sector;
- encouraging representation for private practice physical therapists before governmental, professional and voluntary groups and agencies, and the general public;
- transmitting information on the private practice sector; and
- providing for the dissemination and exchange of information relating to the private practice of physical therapy.

The Private Practice Section was formed to assist individuals who are interested in entering into and managing a private physical therapy practice. These comments reflect the concerns of Private Practice Section members providing services reimbursable under Part B who would be affected by further delays in Medicare claims processing by the Health Care Financing Administration ("HCFA").

Section members in almost every state have recently reported a marked slowdown in claims processing and reimbursement for outpatient physical therapy services. In most cases, providers are experiencing long gaps between payments; in others, payment is made fairly regularly, but the payment cycle is uneven--that is, some but not all claims are paid, others are paid for later. This has resulted in significant cash flow problems for many members.

Recently, one rehabilitation agency servicing Medicare Part B beneficiaries in Pennsylvania reported it had to borrow as much as $14,000 to meet staff payroll. That provider, owed a considerable amount of money by the Medicare program for physical therapy services already rendered, has now reached the bank's limit to its line of credit, and is facing possible bankruptcy. This case is not an isolated event. Other providers throughout the country report that claims submitted to Medicare Part B carriers are not paid for several months, rather than the three to four week time lag from when the claims were originally submitted. One physical therapist in Florida reports a 90-120 day delay in claims processing, compared with a seven-day turnaround just eighteen months ago. For the most part, our members operate small businesses. They do not have huge lines of credit available and cannot afford increased interest rates.

Further, providers have incurred enormous expenditures converting their claims processing systems to electronic billing at HCFA's request--specifically to reduce the amount of time necessary to complete the payment cycle. Now, however, Medicare contractors are insisting that written documentation accompany the electronic transfer before claims can be processed, thus reverting to the system previously used. It becomes clear that the sole purpose of this additional requirement is to further delay claims review and reimbursement.

Reimbursement difficulties do not end with the first provider affected. Many physical therapists are now having to tell their equipment suppliers that they no longer can purchase rehabilitation products because of their increase in Medicare program receivables. In other instances, patients are being asked to pay increased treatment fees for services, in an effort to obtain sufficient funding to pay monthly bills.

Private Practice Section members have taken great pride in being able to provide quality physical therapy services to the aging population in a cost efficient manner. By allowing Medicare claims backlogs to grow, HCFA frustrates this policy of high quality, cost efficient health care. Fewer physical therapy providers can remain viable in this atmosphere and, inevitably, physical therapy services will be sharply curtailed. What this means for Medicare beneficiaries is that fewer patients will receive prompt, comprehensive treatment.

The Private Practice Section urges this committee to instruct HCFA that the claims processing delays to date cannot continue. For the sake of providers and beneficiaries alike, it is imperative that steps be taken to ensure payment in a more timely fashion--either through additional carrier funding for claims processing equipment or personnel, or simply through the streamlining of existing processing procedures. Private Practice Section members are prepared to assist in whatever way possible.

* * *

The Private Practice Section would be pleased to answer any questions or provide additional information.

STATEMENT OF
THE AMERICAN SOCIETY OF INTERNAL MEDICINE
FOR THE RECORD OF THE
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
HEARING ON MEDICARE CONTRACTING
APRIL 22, 1986

The American Society of Internal Medicine (ASIM), an organization representing more than 20,000 physicians who are specialists in internal medicine, takes this opportunity to offer its views on issues related to Medicare contracting. The Society is particularly concerned that current funding levels for claims processing fail to respond to increased demands being placed on carriers during fiscal year 1986 and on the projected growth in the claims workload. ASIM believes that budgetary cutbacks for claims processing have already caused substantial hardship to beneficiaries and physicians.

Since the enactment of the Medicare fee freeze on physician fees and establishment of the "participating/nonparticipating program" in July 1984, hundreds of internists throughout the country have called or written ASIM to report an increasing number of errors and delays in the processing of Medicare claims for themselves and their patients. Problems with carrier performance have already created severe cash flow problems, and increased paperwork burdens on the administrative staff of participating physicians. A number of ASIM members have been forced to take out short-term loans to cover their overhead expenses as a result of increasing delays in payment. The increasing number of errors and delays in the processing of Medicare claims could adversely effect Medicare patients in the future as physicians become discouraged from participating in the program and find it increasingly difficult to accept assignment on a case-by-case basis. In addition, Medicare patients who pay their physicians directly on an unassigned claim basis have already incurred substantial out-of-pocket expenses due to delays in claims processing. Ultimately, the deterioration in claims processing due to budgetary cutbacks is undermining the congressional intent to reduce beneficiaries' out-of-pocket expenses by undermining incentives for physicians to participate or accept assignment.

The extent of the Part B reimbursement problems has led the Society to launch the Carrier Accountability Monitoring Project (CAMP), a program to collect Medicare carrier performance data on a long-term basis. The data collected on carrier performance nationwide will be reported to the Health Care Financing Administration (HCFA) and Congress at least annually. ASIM believes that this project will help HCFA and its carriers identify where problems may exist from the standpoint of physicians and their patients. ASIM recently completed a scientific survey of its membership and plans to make the results available to Congress and HCFA in early June.

The CAMP project grew out of the increasing frustration of internists who collectively treat 43 percent of the Medicare population. Specifically, ASIM members have encountered the following types of problems since the implementation of the fee freeze:

> Carriers are providing incorrect information on Medicare policy and requirements, particularly in relation to the requirements of the fee freeze, including erroneous listing of the participating status of physicians.
>
> Carriers have delayed payment of claims by as much as several months from the date the claim was submitted.
>
> Carriers' phone numbers are repeatedly busy, and they have failed to answer letters from doctors and their patients, making it impossible for physicians' offices to contact carrier representatives to resolve problems.
>
> During the conversion process to the HCFA Common Procedure Coding System (HCPCS) carriers have assigned codes that result in lower payments for the same service then was the case prior to conversion.
>
> Carriers are automatically denying reimbursement for services that exceed prepayment screens (designed to check unnecessary utilization) without medical review of the circumstances in the individual case.

ASIM believes that a number of the problems mentioned above have occurred as a result of the actions taken by the Office of Management and Budget (OMB), Department of Health and Human Services (DHHS), and HCFA to limit federal support for Medicare claims processing. In fiscal years 1985 and 1986, OMB, DHHS, and HCFA have allowed a reduction in funding for claims processing of 7.8 percent, despite an increase of 37 percent in the claims volume during this period. To cope with the budget shortfall, HCFA has instructed carriers to increase their "days work on hand" from eleven days to eighteen days. ASIM is sending a letter today to DHHS Secretary Bowen in opposition to the HCFA directive, urging him to rescind this policy (see appendix I). The additional slow down in payment of claims will cause substantial hardships for beneficiaries and will create disincentives for physicians to accept assignment.

ASIM is also concerned about the inadequacy of the Administration's FY 1987 budgetary request for Medicare contractors. The Administration has requested in its FY 1987 budget a funding level of $957 million, which is less than what Congress considered reasonable for 1986. The Blue Cross/Blue Shield Association has indicated that carriers will need at least a 14 percent increase in funding in order to assure prompt turnaround time on claims and efficient administration of the Medicare program. ASIM supports this recommendation, and believes that sufficient funding is necessary to carry out the congressional intent (as stated in the DEFRA conference report) that "saving measures not undermine beneficiary services, professional relations, productivity investments or program safeguards."

american society of internal medicine

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REPRESENTING
Internists and
All Subspecialists
of Internal Medicine

April 22, 1986

Honorable Otis R. Bowen, MD
Secretary, Department of Health
and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Bowen:

The American Society of Internal Medicine (ASIM) strongly opposes a recent directive from the Health Care Financing Administration (HCFA) to its regional offices ordering a slow down in the processing of Medicare claims.

The current back log in claims processing has already caused severe cash flow problems and increased paperwork burdens on the administrative staff of physicians. A number of ASIM members have been forced to take out short-term loans to cover their expenses (e.g. payroll, mortgage, supplies) as a result of increasing delays in payment. In addition, a growing number of errors and delays in processing claims have caused many ASIM members to question whether continued participation in the Medicare program is desirable. Medicare patients who pay their physicians directly on an unassigned claim basis have already incurred substantial out-of-pocket expenses due to the current delays in claims processing.

HCFA has instructed carriers to increase their "days work on hand" from eleven days to eighteen days to cope with budget cutbacks. These figures do not accurately reflect the additional time physicians and beneficiaries wait for payment because the figures do not include the time claims spend in the mail both to and from the carrier, and those times that carriers are not in operation (e.g., holidays). According to Jack Emery, Senior Washington Representative of Blue Cross/Blue Shield Association, the directive from HCFA "will mean a doubling of the length of time it takes to get paid." He added that "the only way we can (cope with the funding cuts) is to lay off people." This additional slow down in the payment of claims will cause substantial hardships for beneficiaries and will undermine the congressional intent to reduce beneficiaries' out-of-pocket expenses by creating a disincentive for physicians to participate or accept assignment on a case-by-case basis.

ASIM believes that pursuing this course is detrimental to physicians and unfair in its treatment of the elderly. The Society urges you to rescind this directive immediately.

Sincerely,

T Reginald Harris, MD

T. Reginald Harris, MD
President

STATEMENT BY HONORABLE JOHN BREAUX (D-LA)
BEFORE THE HOUSE SUBCOMMITTEE ON HEALTH
APRIL 22, 1986

Thank you for holding these hearings today. The performance of Medicare contractors is a matter of great concern throughout the United States at present. I appreciate the timeliness of these hearings in that the people of the state of Louisiana are facing a serious problem due to the slow payment procedures of Medicare. The problem is felt by health care providers and the many aged of our state who depend on Medicare for payment. I would greatly appreciate your adding this statement to the record of the hearings held April 22, 1986 pertinent to the performance of Medicare contractors.

Mr. Chairman, at present health care providers are experiencing severe problems in that they are not being paid for their services in a timely manner through the Medicare contractor in Louisiana. Health care providers can not afford to stay in business when payment for services is held up for over ninety days in many cases. Acadian Ambulance Service Incorporated, of Lafayette, Louisiana, the largest rural ambulance service in the United States was due $1,207,935.61 in Medicare accounts receivable as of March of 1986. Many smaller companies have been forced to close their doors, or in other cases discontinue service to the elderly dependent on Medicare for payment.

The problem of slow payment extends directly to the individual Medicare beneficiary, many of whom are elderly and/or critically ill. The Medicare dependent patient is in many cases forced to contend with constant payment demands for health care services rendered. The Medicare program was designed to help the elderly and infirmed. Unfortunately, in its current state of implementation in Louisiana, it is in practice acting negatively toward those it was set up to assist. The problem is serious and continues to worsen as the backlog of claims grows, due to what the carrier, Blue Cross-Blue Shield of Louisiana claims is a breach of contractual agreement with the Health Care Financing Administration.

On January 1, 1985, Blue Cross-Blue Shield of Louisiana took over the handling of Part B, replacing The Pan-American Life Insurance Company, an insurance carrier that had handled Part B for eighteen years prior to the takeover. Blue Cross-Blue Shield of Louisiana was contracted to handle Medicare Part B by the Secretary of Health and Human Services, and feels as if the Health Care Financing Administration is not living up to their end of the contract. This they claim is the rationale behind the dire situation health care providers and beneficiaries are currently facing in Louisiana.

I recently received a letter from Blue Cross-Blue Shield of Louisiana explaining in great detail its reasoning behind the slowness of their payment procedures. It is my understanding through this correspondence, that they feel as if they were underfunded by $1,211 000 for Fiscal year 1986 and are in need of an additional $200,000 to reduce the current beneficiary services backlog to an acceptable level.

I am issuing this statement because I feel the health care providers and the individuals to whom they administer are suffering in Louisiana. I have received many letters from health care providers and elderly constituents regarding the severity of the situations they are experiencing. From a business standpoint, providers can not operate without punctual payment for their services. Operational costs add up as Medicare debts remain outstanding. From the viewpoint of the ambulance provider, gas tanks must be filled, medical supplies must be purchased, and employees must be paid. Many providers have been forced to take out short-term loans to meet operating expenses.

I find it hard to understand why interest should accrue against the private health care provider while it accrues positively for the Health Care Financing Administration trust fund. The problem experienced by the provider is quickly transmitted to the elderly and poverty stricken dependent on Medicare for health care payment. The elderly, in particular, become considerably concerned when they must carry the burden of outstanding debts. This, in many cases causes physical conditions to deteriorate and acts in in keeping them from seeking necessary future medical assistance because of the intense pressure felt as bills accumulate.

I believe that some action must be taken to increase the efficiency of Medicare's payment procedure in Louisiana. As I mentioned, the Medicare program was initiated to help the elderly and infirmed of our country. Unfortunately, the slow payment problem is producing the opposite effect in that it is limiting the range of health care services provided, and the number of companies available to provide them. I appreciate the Subcommittees consideration and any action that may be taken to solve this problem.

STATEMENT

Reid W. Baddeley
President
Health Care Contractors Association

The Health Care Contractors Association (HCCA) hereby submits this statement in response to the request of the Subcommittee on Health, House Committee on Ways and Means, for written testimony on current issues affecting Medicare contractors. HCCA is particularly concerned with growing claims volume, and with the adverse effects on providers and beneficiaries alike of Health Care Financing Administration (HCFA) instructions to contractors that Medicare claims backlogs be allowed to grow, and that assigned claims be processed more slowly.

HCCA is a non-profit trade association of companies providing physical and respiratory therapy and durable medical equipment (DME) services under contract with over 500 hospitals, home health agencies, long-term care facilities, health maintenance organizations, and other providers. HCCA member companies and their hundreds of employees operate in virtually every state across the country. HCCA member companies providing services reimbursable under Part B continue to be affected by the growing delays in Medicare claims processing by HCFA carriers.

HCCA member companies are concerned that claims backlogs which have been increasing over the last six months could seriously hamper the quality of patient care services furnished, particularly in the home-care setting. Medicare's prospective payment system for hospital reimbursement was created specifically to enhance earlier patient discharge from hospitals and to promote home care. Unfortunately, HCFA's recent instructions to Medicare contractors to delay payments to Medicare providers, as well as create a large backlog of Medicare claims, are causing significant financial strain on home-care providers which furnish necessary medical services and supplies for Medicare beneficiaries. These services and supplies have been made available at a much lower cost in the home-care environment than could be provided by a hospital.

HCCA members have taken great pride in being able to provide quality services to the aging population. Efforts by HCFA to frustrate this policy of providing high-quality health care by allowing Medicare claims backlogs to grow will inevitably result in curtailment of services. Fewer providers can remain viable in this atmosphere. This only means that fewer Medicare beneficiaries will receive prompt, comprehensive treatment.

For example, one upper New York State Medicare carrier has informed an area DME supplier that HCFA is requiring it to hold claims up to 23 days before even beginning processing. Reportedly, unopened boxes of Medicare claims line the halls of the carrier's office. The growing backlogs have affected cash flow to the point that the supplier is seriously reevaluating whether the company can continue to accept Medicare assignment. By the carrier's holding of these claims, the DME supplier's payment cycle becomes 50-90 days on a "clean claim," and if additional information is required, the supplier may have to wait from 180 to 240 days for payment. One HCCA member company dealing with approximately 35 carriers estimates the average claims turnaround time to be 120 days nationally. These delays in claims processing may force companies in the health care industry, such as DME suppliers and therapists, to curtail business operations, to the detriment of the Medicare population.

The Medicare carriers with which HCCA members report having the most significant processing delays are Pennsylvania, New York, Michigan, Florida, Louisiana, Massachusetts and Oklahoma. Some carriers -- Oklahoma, for example -- reportedly are denying Medicare claims outright, stating that they are awaiting "further information" but are refusing to advise suppliers of the nature of the needed information. Suppliers' efforts to assist in expediting claims' processing thus are being rebuffed.

HCCA recommends the approval of additional carrier funding earmarked for resolution of these difficulties. At a minimum -- additional funding notwithstanding -- HCCA recommends that carriers be instructed that current claims processing delays are unacceptable, and that efforts be undertaken immediately to eliminate backlogged claims.

* * * *

The Health Care Contractors Association would be pleased to answer any questions or provide additional information.

HIDA HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION

PAUL B. SIMMONS
President

1701 PENNSYLVANIA AVENUE, N.W., SUITE 470, WASHINGTON, DC 20006 202 659-0050

May 9, 1986

SUBCOMMITTEE ON
RECEIVED
MAY 12 1986
HEALTH

The Honorable Fortney H. Stark
Chairman
Subcommittee on Health
Ways and Means Committee
1114 Longworth House Office Building
Washington, DC 20515

Dear Mr. Stark:

The Health Industry Distributors Association submits the following comments and information regarding delays in payments for durable medical equipment (DME) and oxygen under Medicare Part B for the record of the hearings of the Subcommittee on Health on administration of the Medicare program held on April 22.

Most testimony at those hearings focused on plans by the Health Care Financing Administration to increase the current contractor claims payment time. HCFA Acting Administrator for Operations Kevin Moley stated that "an increase in claims payment time has been necessitated, from an average payment time at the end of FY '85 of 15.6 days under Part A and 20.0 days under Part B to 30 days under both programs by the end of FY'86".

For the home health care equipment supply industry, it is ludicrous of HCFA to speak of an FY '85 average payment delay of 20 days. We are enclosing the summary of a survey of our members conducted since your hearing on April 22. The average payment delay for claims for DME and oxygen for the carriers included is between 2.4 and 2.6 months. Further information from several national firms providing supplies in other jurisdictions indicate that delays of this magnitude are representative of problems occuring throughout the industry.

We agree with other witnesses that it is unconscionable for the government to instruct carriers deliberately to slow down payments. Unfortunately, our concern is not, however, a theoretical stretching of the payment time from 22 to 30 days. Our members would be delighted to be assured of payment in 30 days. In too many localities, the DME and oxygen supply industry is not at present receiving the courtesy of even a serious attempt to process claims within 30 days.

As noted by Mr. Foley, while the Prompt Payment Act does not at present apply to the Medicare program, it does provide Congressional guidance, "requiring the government to pay bills as close as possible to the 30th day after receipt." At present, HCFA and many of its carriers are deliberately flouting the Prompt Payment Act. Average delays of 2.4 months are unconscionable.

We urge that Medicare carriers be required to pay or respond to Part B claims within 30 days. As under the Prompt Payment Act, interest should be paid on claims that have not been paid or responded to within 30 days.

Carriers of course have the right, and in some cases should, request further development of a claim and to deny claims which are incorrect. However, our members in some localities are finding a high percentage of denied claims which are later paid on appeal. We are also confronting delays caused by repeated requests for submissions of physician statements of medical necessity which had been submitted previously and apparently lost or misplaced by the carrier. Claims review cannot become a subterfuge for delayed payment. We urge, therefore, that the requirements for the payment of interest after 30 days should apply when a claim which was initially denied is subsequently approved, or where a delay is demonstrated to be due to an error by the carrier.

Where carriers are unable to process and pay claims for DME and oxygen within 30 days, as an alternative to payment of interest, interim payments should be made covering 90 percent of claims submitted. If, on subsequent review of the claims, it is determined that any overpayment was made, the supplier should pay interest to the government on any such overpayment.

Medicare contractor funding was also discussed at the recent hearings of the Subcommittee. We doubt that the current inexcusable delays in processing Part B claims for DME and oxygen are in all cases traceable to reductions in contractor funding. However, it is obvious that contractors must receive sufficient funds to carry out their obligations to beneficiaries, to suppliers, and to the Medicare program. The draft of the General Accounting Office report on Medicare Contracting reviewed at your hearings does conclude that "HHS recent efforts to unilaterally cut administrative costs are inconsistent with Congressional intent that cost cutting measures not adversely affect program payments and the quality of services to beneficiaries and providers." We urge that the Congress review the findings of the GAO and provide contractors with the funds required for fast and efficient processing of Medicare Part B claims.

We appreciate the subcommittee's review of this subject and look forward to providing further information.

Sincerely,

Paul B. Simmons
President

Robert H. Wilbur
Vice President/
Government Relations

May 8, 1986

HIDA QUESTIONNAIRE
DELAYS IN PAYMENT OF CLAIMS UNDER MEDICARE PART B

	1. Average delay Rental claim DME > $120.00	2. Average delay rental Oxygen Equipment	3. Average delay purchase equip. less $120.00	4. six months ago	5. one year ago
CALIFORNIA					
Blue Shield Corona	90 days	90 days	90 days	worse	worse
Blue Shield Jackson	10-30 days	30-45 days	10-30 days	worse	worse
National Firm Orange	xx	xx	xx	worse	worse
TransAmerica Occidental San Diego	2 1/2 months	xx	2 months	better	better
TransAmerica Occidental Whittier	90 days	90 days	see form	worse	worse
CONNECTICUT					
Cigna Middletown	10-12 weeks	8-10 weeks	8-10 weeks	worse	worse
Conn. Gen Life Insur.	4-5 months	xx	4-5 months	worse	worse
DELAWARE					
Pennsylvania Blue Shield	xx	xx	xx	worse	worse

xx = no remark

	Average delay Rental claim DME > $120.00	Average delay rental Oxygen Equipment	Average delay purchase equip. less $120.00	six months ago	one year ago
FLORIDA					
Boca Raton	xx	2-3 weeks	2-3 weeks	better	xx
ILLINOIS					
BC/BS RockFalls	45-50 days	55-60 days	45-50 days	worse	worse
INDIANA					
BC/BS Elkhant	2-4 months	3 months	3-4 months	worse	worse
BC/BS (Kentucky) Nationwide BC/BS Ind.	59 days	76 days	59 days	better	worse
BC/BS Mass. Waterville	3-4 weeks	3-4 weeks	3-4 weeks	worse	worse
NEW JERSEY					
BC/BS PA Prudential Cherry Hill	3 months	6 weeks	1 month	xx	xx
Prudential Toms River	8-12 weeks	8-12 weeks	5-8 weeks	same	xx
NEW MEXICO					
Equitable Life Assur. Hobbs	90 days	90 days	90 days	better	better
NEW YORK					
BS Western NY Albany	6 months	6-9 months	9 months	worse	worse

	Average delay Rental claim DME > $120.00	Average delay rental Oxygen Equipment	Average delay purchase equip. less $120.00	six months ago	one year ago
Empire BC/BS Hicksville	6-8 weeks	6-8 weeks	6-8 weeks	better	same
BC/BS G NY Larchmont	90-120 days	30-60 days	60-90 days	worse	better
BC/BS Long Beach	2-4 weeks	3-6 weeks	2-4 weeks	better	better
BS W NY Binghampton	4 months	4 months	4 months	worse	worse
BS W NY Binghampton	6 weeks	6 weeks	6 weeks	same	same
NORTH CAROLINA					
Prudential Wilmington	6-8 weeks	8-10 weeks	xx	worse	worse
OHIO					
Nationwide Mutual Ins.	4 week	4-5 weeks	4 weeks	better	better
PENNSYLVANIA					
BS PA Easton	xx	xx	xx	worse	worse
BS PA Luzerne	2 months	3 months	3 months	same	better
BS PA Pittsburgh	see form	2 months	2 months	better	worse
BS Travelers PA Pitts	4-6 months	2 months	3-4 months	worse	worse
BS PA Philadelphia	3 months	6 months	3 months	worse	worse

	Average delay Rental claim DME > $120.00	Average delay rental Oxygen Equipment	Average delay purchase equip. less $120.00	six months ago	one year ago
BS PA Wynnewood	33 days	xx	25 days	xx	xx
BS PA Pottstown	4-6 weeks	6-8 weeks	4 weeks	better	better
PUERTO RICO SSS of PR Ponce	6 months	6 months	6 months	worse	worse
RHODE ISLAND BC/BS RI Warwick	3 months	3 months	2 months	worse	worse
TENNESSEE Medicare Equitable Adm Nashville	90-120 days	90-120 days	60 days	worse	worse
WISCONSIN WPS Madison Madison	21 days	21 days	21 days	same	worse
	2.6 months	2.7 months	2.4 months	20 worse 9 better	22 worse 7 better

* The numbers represent the Arithmetic mean of the actual responses to the specific question.

HOMECARE

NATIONAL ASSOCIATION FOR HOME CARE
519 C STREET, N.E., STANTON PARK
WASHINGTON, D.C. 20002
(202) 547-7424

ELSIE L. GRIFFITH
CHAIRMAN OF THE BOARD
VAL J. HALAMANDARIS
PRESIDENT

HONORABLE FRANK E. MOSS
SENIOR COUNSEL
MOSS AND WILKINS

May 9, 1986

Joseph K. Dowley
Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Dowley:

On behalf of the over 3,000 members of the National Association for Home Care (NAHC), I am pleased to have this opportunity to submit our comments on Medicare contracting problems that are affecting providers and beneficiaries of home care services. NAHC is the nation's largest association representing home care professionals and paraprofessionals. As of late, the problems home health agencies (HHAs) have experienced with claims processing delays and denials of coverage by fiscal intermediaries (FIs) throughout the country have become exacerbated. Our comments will describe these and other difficulties that have arisen with Medicare contractors and the Health Care Financing Administration (HCFA), and will outline recommendations which NAHC believes will help remedy these problems.

Claims Processing Delays

HCFA has testified before this Subcommittee that, in order to live within a reduced contractor budget for FY 1986, "an increase in contractor claims payment time has been necessitated." This "temporary inconvenience," HCFA states, purportedly will save the Medicare Trust Fund $132 million in interest.

Without question, HCFA has been successful in achieving its objectives, as numerous delays of well over 120 days are being reported by HHAs around the nation. A recent survey conducted by the Louisiana Association of Home Health Agencies found that 18 percent of those responding had not received Medicare payments in over 120 days, and 2 agencies were each owed over $300,000. Oklahoma providers are receiving denial notices in March 1986 for services rendered and claims submitted in November 1985. Similar delays have been documented in Pennsylvania, Minnesota, Wyoming and Montana. During the March NAHC Legislative and Regulatory Conference, the following reports on slowdowns were received:

- . California - backed up from July 1985
- . Illinois - 3 to 4 months behind; many claims "lost"
- . Nebraska - 3 to 6 months behind
- . Michigan - processing November 1985 bills in March 1986

- Georgia - in excess of 2 months behind
- Arizona - 3 months behind
- New Mexico - 2 to 3 months behind
- Missouri - 3 to 5 month delays
- Delaware - 2 to 3 months behind
- Florida - 4 to 5 month delays
- Mississippi - 3 to 4 months behind
- Tennessee - 3 to 6 months behind
- Indiana - delays extensively beyond 2 months
- North Dakota - 4 to 6 month delays, with triple requests for the same information
- Oregon - 87 claims with 3 or more month delays

As these reports indicate, the situation is already out of hand. In an effort to get uniform national data on the extent of this problem, NAHC is in the process of completing a nationwide survey on the HHA claims payment delay problem. Preliminary results clearly confirm the experiences reported above. With 237 agencies across the country responding:

- 77 percent reported that, since September 1, 1985, they have noticed an appreciable delay in the time it takes Medicare to pay a claim.

- 74 percent report that, during the past 6 to 9 months, the average lag time between the date claims are submitted and the date payment or denial is received is 2 months or more.

When these kinds of unreasonable delays in payment exist, many providers are forced to take drastic measures. Already, reports have been received showing that several providers in California and Illinois have been forced to sell their agencies because they could not meet their payrolls. According to our national survey, almost one-third of the respondents are also unable to meet their payrolls, while 60 percent are incurring additional administrative costs and half cannot pay their bills on time. We are also very concerned that 20 percent report they are being forced to reduce indigent care while 11 percent have had to reduce services to beneficiaries.

It is not only naive, but dangerous to assume that by encouraging slowdowns in claims processing, HCFA is "saving" money with only minor inconvenience and no other significant costs being extracted. Delays inevitably elicit the responses described above, and providers must also increase short-term borrowing at substantial interest costs, borne in part by the Medicare program. Thus, interest costs are simply shifted unfairly onto the shoulders of HHAs and other providers, who must pay what, in effect, are increased taxes.

NAHC must also question the savings estimates cited by HCFA. Medicare contractors have continually argued to deaf ears that allowing Days Work on Hand (DWOH) to escalate does just the opposite of saving Federal dollars. The Health Insurance Association of America has testified before this Committee, stating: "Seven of the larger contractors, representing 40 percent of the Part B claims, conducted a study of the cost vs. savings. Extrapolated from the study, figures show a backlog of 18 DWOH will generate a one time savings of $5.8 million but will be offset by an annualized cost of $18.2 million. These are very conservative figures, in that all areas that could not be quantified were eliminated. [Emphasis in the original]."

Claims payment delays increase the number of duplicate bills submitted, producing an even greater workload for an already overloaded system. Since the workload is simply building up more and more, one can anticipate that the delays described above will only grow worse as the year progresses, unless something is done. Increased provider and beneficiary inquiries will also raise program administrative costs and exacerbate the backlog problem. Other reactions to the problem include reduced submission of electronic claims and reduced assignment rates.

The cash flow problems caused by these delays are having a more significant adverse effect in the home health area than for any other type of health provider. This is true for four reasons: (1) Claims processing delays were already longer for HHAs than for other providers. The HCFA "Intermediary Bill Processing Time Report" shows that the time taken to process bills for HHAs exceeded that of inpatient, outpatient, and skilled nursing facilities; (2) HHAs rely on Medicare payments, on average, more than other health care providers. Medicare accounts for approximately two-thirds of HHAs' revenues, with many agencies relying 100% on the program; (3) HHAs tend to be smaller businesses than other health care provider, making it more difficult to borrow money against capital and (4) HCFA has vastly increased administrative and other costs to HHAs over the past year while reducing total reimbursement rates. Hospital DRGs have also resulted in patients needing higher acuity, more expensive home care services, while HCFA continues to use FY 1983 data (just before DRGs went into effect) computing cost limits.

While increasing appropriations for claims processing budgets will certainly make it easier for contractors to reduce delays, NAHC believes there are other causes which also shed light on the nature of the problem. HCFA reports that the average national intermediary processing time was 22.5 days in the first quarter of 1986--higher than any other provider group. If one considers mailing time, printing and sorting time, and summary check cycles, a claim should take, in the worst case, about 47 days to pay--from the time it is mailed out to the time it is received. This still does not account for the voluminous reports of delays of well over 60 days. What accounts for this discrepancy? The answer is that contractors are not entering claims into the processing system when they are received. NAHC has evidence that, rather than logging in claims within 24 hours of receipt as required by law, contractors are letting them sit on the shelf for weeks, or "mothballing" the claims, or are conveniently "losing" them. We have compiled evidence of over 100 claims which took weeks, and sometimes months, to be entered into the claims processing system after they had been physically received by the contractor.

For example, a claim submitted on November 27, 1985 was not logged into the system until January 7, 1986. Another claim submitted December 11, 1985 was logged in on January 16, 1986. Another claim submitted December 19, 1985 was logged in on January 30, 1986. The list goes on. This reveals a systematic effort not only to delay the time it takes to process a claim, but to let claims sit for many weeks before they are even entered into the claims processing system! Such behavior is clearly illegal and must not be tolerated. Mechanisms seemingly do not exist at present to ensure that claims are logged in promptly. Such a mechanism must be devised and enforced.

Besides supporting increased appropriations for claims processing functions, and improving PIP, devising a mechanism to ensure that claims are logged in when they are received, NAHC also makes the following recommendations for addressing the claims payment delay problem:

(1) Require that FIs process and pay claims within a reasonable period of time, after which they should be required to pay interest;

(2) Institute a system of prior authorization of claims, where coverage determinations are made before services are rendered. At a minimum, create a system for an expedited review of claims;

(3) Change the Contractor Performance Evaluation Program (CPEP) "timeliness" standard to account for time taken to pay a claim in addition to mere DWOH, and make it a "critical element"; and

(4) Make it easier for HHAs to receive periodic interim payments (PIP) and accelerated payments.

Claims Denials and "Technical" Denials

NAHC has evidence showing that contractors have vastly increased Medicare denials of coverage for HHAs relative to previous years. Home health agencies throughout the country have experienced alarming increases of denials of coverage for home visits. Fiscal intermediariess are issuing blanket denials of what is clearly skilled and medically necessary care of the type and intensity for which coverage was approved in prior years by the same intermediaries reviewing equally detailed cases. Fiscal intermediaries are also issuing partial denials, reducing approved payments from 3 to 2 visits per week, for example, despite physician orders for the greater number of visits and demonstrated need in the given case. Such partial and complete denials have not been preceded by any communication from HCFA or the FIs as to medical, scientific or regulatory bases for changes in coverage policy. Furthermore, FIs in different states are handling similar coverage situations differently, continuing the national pattern of inconsistent policy application.

In addition, HCFA policy makers have created a form of coverage denial called "technical denials' which are increasingly being imposed on HHAs. Technical denial of a visit is based on the FIs determination that the visit failed to meet a statutory or regulatory requirement other than medical necessity. By HCFA edict, technical denials are not subject to payment under waiver of liability and are appealable only by the beneficiary. Examples of "technical" denials are those where the FI finds the client did not meet the homebound or "in need of intermittent skilled nursing care" eligibility requiirements despite the fact that the treating physician and home health agency have made professional medical judgments that the patient has done so. Other "technical" denials may be based on the FI's determination that the patient received a non-skilled or other service not covered under the Medicare home health benefit. Recently, HCFA has directed FIs to treat as "technical denials" home health aide visits monitored as part of a skilled service which the FI denies but pays under waiver. This effectively abolishes any opportunity for the provider to appeal any aspect of the associated denials, and has resulted in extensive financial harm to many HHAs.

Fiscal intermediaries are responding to HCFA's pressure to lower the total dollar amount of Medicare home health services approved, despite Medicare beneficiaries' entitlement under the statute to the full range of medically necessary home care. To satisfy immediate HCFA demands for "savings," FIs are issuing arbitrary and erroneous coverage decisions which then must be appealed - an unnecessary increase of the long-term administrative costs of Medicare. Fiscal intermediaries should be provided with clear, consistent written instructions on the range of treatments and diagnostic conditions for which HCFA develops coverage policies of limitation of payment. These HCFA policies should be developed in keeping with statutes and regulations after open, detailed discussions with clinicians and administrative personnel from the home care setting. HCFA should also consult with others actively involved in the referral of patients for home based care: hospitals, SNFs, and physicians should be consulted concerning the acuity levels of patients HHAs can be treating. Policies of HCFA limitation or noncoverage should be applied prospectively after their dissemination to HHAs.

NAHC also believes that the "technical denial" should be eliminated. Denials of aide visits should be paid under waiver when the associated skilled visits are paid under waiver. When terms like "homebound," "intermittent," and "skilled nursing" directly relate to medical orders which physicians sign to permit HHAs to render care under the home health benefit, and to the medical and nursing assessments of the patients which the HHA must perform on an ongoing basis, the HHA should have the right to appeal such denials directly. Such "technical" terms are no more definitive than the term "medical necessity" -a term not subject to the technical denial policy. Medicare beneficiaries rely upon the medical and nursing assessments of the HHA, and the HHA relies upon the patient for accurate information about the patient's activities and subjective responses to treatment. HCFA's "technical denial" policy fractures this relationship of caregiver and patient and is an illogical interpretation of the statute as now written.

NAHC believes HCFA's "technical denial" policy is another attempt to create Medicare "savings" because HCFA is aware that most Medicare patients, their families or survivors may lack either the understanding or the stamina to appeal a "technical denial" on their own. It is simply not realistic for home health agencies to expect or even attempt to recoup from frail people in strained financial and emotional situations the costs of months of care disallowed by FIs. Having already paid staff salaries, HHAs are left with tremendous financial losses.

The Medicare beneficiary is harmed since the HHA which rendered care is barred by current HCFA policy from joining in or leading the appeal. Medicare beneficiaries are also adversely affected because HHAs facing severe monetary losses from "technical" denials must avoid care of patients whose care might result in a "technical" denial. For example, most technical denial cases on the "not intermittent" care issue are won by patients at the impartial administrative law judge level.

However, HHAs cannot be confident that these appeals will be brought by sick, exhausted patients or bereaved families. HHAs will begin to limit the number of these patients, or cut back on needed visits, or simply not bill for visits that are made-which no business can afford to do for long. The result is an inevitable narrowing of the Medicare home health statutory benefit.

NAHC will continue to identify and collect information on cases which HHAs believe involve medical necessity decisions improperly classified as "technical" denials. NAHC will coordinate with agencies and beneficiary groups to seek a change in policy interpretation by HCFA, or other legal remedies as may be necessary.

NAHC strongly supports provisions in H.R. 4330, H.R. 4638 and S. 2331 which would permit "technical" denials to be appealed and allow providers to represent beneficiaries in Medicare appeals. NAHC also supports extending waiver of liability coverage to "technical" denials. They are subject to the same vagaries as the policies governing medical necessity determinations, which of course, are covered by the waiver. A problem that is likely to arise under this provision is that Medicare coverage denials will increase to a level over 2.5 percent of claims submitted. Therefore, many HHAs could lose their waiver status completely unless the 2.5 percent figure were adjusted upward, since "technical" denials are not currently part of the computation of the 2.5 percent. Since fiscal intermediaries (FIs) have increased the number of "technical" denials as of late (for example, during the first quarter of 1986, 33 percent of all denials received by providers of Oklahoma were "technical", while in 1985, only 5 percent were "technical") extending waiver in this manner will almost surely push the denial rate for HHAs over 2.5 percent. We, therefore, recommend that the waiver threshold be raised to 5 percent for HHAs. This would make the level equal to that for SNFs. There is no reason to make any distinction between the two. With HHAs shifting to a system of ten new regional intermediaries, it is particularly important that the waiver threshold be increased to 5 percent so that providers won't lose their waiver as they adapt to the differing interpretations of the Medicare regulations and guidelines their new FIs.

NAHC also recommends that the Contractor Performance Evaluation Program (CPEP) be altered to correct the incentives it creates for contractors to deny coverage. Currently, critical elements concerning cost savings far outweigh elements designed to measure the accuracy and timeliness of coverage determinations, as well as the adequacy of explanations for denials. One cost savings element consists of a benefit savings payback ratio, in which contractors are told that they should save at least $5 in the audit and medical review process for every $1 of administrative costs expended on these functions. The existence of such arbitrary targets encourages FIs to deny coverage in those "grey areas" where discretion is involved, so that they will receive a higher CPEP score. Thus, rather than assuring that accurate review determinations are made, the CPEP provides incentives to save money by denying virtually all but the most clearly covered claims. The Blue Cross and Blue Shield Association has testified before this Subcommittee that, "Important elements of a contractor's activities, such as making accurate coverage determinations are not weighted as heavily in the evaluation system as payback measures." It seems that everyone but HCFA recognizes the biased decisions that are being encouraged by this evaluation program.

In order to address this grossly unfair bias in the CPEP, NAHC strongly supports provisions in H.R. 4330 which:

Require that DHHS develop new criteria and standards for evaluating intermediary performance under the CPEP that:

(1) Give equal weight to "accuracy" as to "cost savings" in intermediary decisions under both their medical claims review and cost report review functions.

(2) Establish "accuracy" and "timeliness" in both medical claims review and cost report review as critical variables such that failure to meet standards under these, as with other CPEP critical variables, is grounds for termination of contract.

(3) Replace the current 5:1 minimum standard for cost-savings under the medical claims review and cost report review functions with measures and standards of cost-effectiveness that are not based on numerical standards alone.

(4) Increase the weighting of performance criteria related to the completeness of explanations for denials under both medical claims review and cost review functions.

Require that DHHS provide information on overall intermediary performance (such as data on claim denials and reversals by region and intermediary including decisions from Administrative Law Judges and judicial proceedings) for the purpose of evaluating and revising criteria under the CPEP. We are also concerned that coverage requests get arbitrarily denied because far too many FI employees without adequate background or training are reviewing HHA claims for payment. For example, we should not permit a pediatric nurse to review home health claims for elderly patients, or a nurse without clinical experience for many years to review claims for therapy and other services. When an employee with a nursing degree as the only qualification for being hired reviews claims, the chances for making an erroneous decision are much greater. NAHC, therefore, recommends that a technical Advisory Panel be created, with members including provider, beneficiary, FI and HCFA representatives, to set training and qualification standards for these claims reviewers, and to investigate allegations of inappropriate personnel conducting claims reviews.

In general, we also believe that the entire Medicare home health coverage criteria are faulty and outdated. For example, since patients are being discharged to HHAs in a sicker condition than before the advent of DRGs, the intermittent care requirement needs to be re-examined. NAHC is thus very supportive of provisions in H.R. 4330, H.R. 4638, and S. 2331 which would examine and develop an improved uniform needs assessment instrument for determining Medicare coverage of HHA services.

On a final note, we are very hopeful that the move to ten regional fiscal intermediaries for Medicare HHAs will improve the consistency of coverage determinations, as well as their accuracy and timeliness as a result of greater specialization and expertise. NAHC believes that a set of conditions should be developed to grant HHAs a presumptive right of reassignment to an alternate FI based on patterns of delay in claims processing, payment, or other indications of poor performance. In general, we feel that HCFA should commit to minimizing disruption of HHA cash flow; prohibiting subcontracting of auditing and review functions; making FIs accountable for prompter bill processing and more timely, consistent and accurate coverage determinations. NAHC does not agree that costs of the transition should be treated under general, i.e., step down principles of reimbursement. These costs should be a direct 100% pass-through and reimbursed in full.

Finally, we hope that this transition will provide a new opportunity for providers and contractors to work together and improve lines of communication. Far too often, unwritten guidelines and new illustrations of coverage criteria have been changed without the knowledge of those submitting the claims. Thus, while the regulations and written policies themselves have not changed, several contractors have admitted that new interpretations of old terms have occurred absent any form of communication to providers. A vast increase in denials on the basis of "homebound" criteria, for example, can be attributed to such an unwritten change in internal guidelines.

NAHC very much appreciates the opportunity to present our views on these matters and wants especially to thank Chairman Stark for holding this important hearing and taking the initiative to address many of these difficulties in his legislation, H.R. 4638. We look forward to working with the Subcommittee in solving some of the problems described here.

Sincerely,

Val Halamandaris

Val J. Halamandaris
President

STATEMENT OF
THE NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS

U. S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
APRIL 22, 1986

MEDICARE CONTRACTOR PROBLEMS

The National Association of Medical Equipment Suppliers, a non-profit trade association, represents nearly 2,000 suppliers of Durable Medical Equipment under Part B of Medicare. On behalf of our members, we would like to thank the Committee for focusing attention on the growing problem of reimbursement delays resulting both from reductions in program administrative funding as well as numerous, uncoordinated program changes which have confused beneficiaries, carriers and suppliers, alike.

NAMES strongly supports adequate funding for the administrative expenses incurred by Medicare carriers and intermediaries. Our members feel that it is unrealistic to expect firms charged with administering Medicare programs to absorb the costs associated with increased claims volume, particularly at a time when these firms, as well as providers and suppliers, are being asked to make huge investments in electronic claims processing hardware and software. Inadequate support for carriers at this critical time is unrealistic and has brought Medicare's reimbursement system and suppliers under Part B virtually to the point of collapse.

The 1980s have been a time of reassessment and change for healthcare. Modalities and structures that served Medicare since 1965 have been reevaluated and, in some instances, totally discarded, in favor of newer approaches meeting new objectives. Many of these changes were timely and desirable; the Diagnostic Related Groups (DRGs) are but one example.

The DRGs were a reasoned approach to correct the problems inherent in cost-based reimbursement and, by and large, have been responsibly implemented in ways that permitted Congressional and industry input both in design and implementation. Unfortunately, this open, reasoned approach to social policy development has not been extended beyond Part A to the Durable Medical Equipment (DME) suppliers, physicians and others who provide equipment and services under Part B.

The reasonable charge methodology under Part B, like the old cost-based reimbursement for hospitals, may be inappropriate now, 20 years later. It is said to be inherently inflationary and ill conforming to recent changes in the marketplace. Unfortunately, rather than seek reasoned, consistent legislative changes, the Administration has resorted to a series of ad hoc, uncoordinated changes designed to change the fabric of the Part B reimbursement methodology without Congressional or industry consultation. In the last 12 months, we have seen eight major administrative initiatives applied to the DME industry:

- the Common Procedure Coding System,
- the rent/purchase program,
- various PATROL/VAP initiatives,
- the "inherently reasonable" criteria,
- a freeze in FY 1986 reimbursement,
- the Oxygen guidelines,
- proposed national rates for parenteral and enteral nutrition, and
- the February 18, 1986, proposed rule under which HCFA accords itself virtually unfettered authority to establish whatever price it chooses for DME and physician services.

The impact of these ad hoc changes on carriers and suppliers alike has been devastating:

- Numerous DME suppliers now report Medicare accounts receivable exceeding 120 days, causing severe cash flow problems and, in some cases, documented bankruptcies.
- Carrier statistics, which show increases in Days Work On Hand, do not accurately reflect the magnitude of the problem, both because the average of all Part B claims outstanding (including physicians) does not accurately reflect the significantly larger than average backlog of DME claims, and because these reports do not take into account thousands of claims which have not been entered into the processing system at all. Too often, claims are simply thrown away or left to gather dust.
- Carriers either have been or will be reducing staff levels essential to the timely processing of claims.
- The incentives for large investments in electronic claims media (ECM), which will save time and money over the long run, are being reduced.
- New providers and suppliers entering the field can expect serious cash flow problems which will threaten their ability to provide quality health care. If these conditions persist, competition will be reduced.
- Fewer providers and suppliers will be willing to accept assignment and wait 120 days for reimbursement, thereby shifting financial burdens to beneficiaries, many of whom will be unable to pay for the services and equipment essential to their health and well-being.

To be candid, we are not exaggerating when we say that reimbursement delays are already curtailing our industry's ability to provide equipment and services. We cannot pay our bills. We are borrowing money to meet current financial obligations. And, some dealers have been forced to seek protection under Chapter 11.

Our carriers are grappling with the same problems as best they can. Budget constraints and increasing workloads are a fact of daily life and likely to remain so in the absence of clear Congressional action. It is clear that the Administration is unwilling or unable to address the problem.

We recommend the following action:

- Increase appropriations for claims processing.
- If increased appropriations for claims processing are not possible, then make some arrangement whereby claims not processed within 30 days will be paid and subsequently audited with later adjustments for over- or under-payments.
- The ultimate solution to many of the problems confronting carriers, suppliers and beneficiaries lies in a systematic legislative change of the current Part B methodology. We acknowledge the need for reasoned, carefully constructed changes in Part B and we respectfully propose a six-point plan of action designed to correct problems in the DME portion of Part B. Our recommendations follow:
    1. Retain the current rent/purchase methodology for inexpensive equipment, e.g., items costing less than $120.
    2. Establish three categories for expensive equipment:
        - Category A: Unlimited Rental of high-risk or service-intensive equipment, e.g., respiratory equipment.
        - Category B: Rental of other equipment, but capped in terms of a number of months, e.g., hospital beds.

- Category C: Defined exceptions where purchase is appropriate, e.g., customized equipment, consumables and disposables.

3. Establish a national pricing system which moves away from the historical reasonable charge methodology and toward a system of adjustments tied to the Consumer Price Index.

4. Establish a small "ProPAC"-type advisory committee to review DME reimbursement levels and recommend appropriate adjustments, either upward or downward.

5. Reduce the number of carriers servicing DME beneficiaries and suppliers.

6. Uniformly enforce the collection of co-insurance and deductibles.

Mr. Chairman, Members of the Committee, thank you for the opportunity to discuss this pressing problem. Our association stands ready to work with Congress and the Administration in a mutual effort to correct deficiencies in the Part B program. All of us share a profound responsibility in our efforts to provide quality health care to the nation's poor and elderly.

Respectfully submitted,

Thomas M. Antone

Thomas M. Antone, IV
President

STATEMENT OF THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES, NATIONAL EASTER SEAL SOCIETY, AND THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

This statement is submitted jointly by the National Association of Rehabilitation Facilities (NARF), the National Easter Seal Society (Easter Seals) and the American Occupational Therapy Association (AOTA) to the Subcommittee on Health for inclusion in the record of its hearings on medicare contracting.

NARF is the principal national membership organization representing medical and vocational rehabilitation facilities. Its membership includes approximately 300 providers of services to medicare beneficiaries, including freestanding rehabilitation hospitals, rehabilitation units of general hospitals, comprehensive outpatient rehabilitation facilities, home health agencies, skilled nursing facilities and rehabilitation agencies. Easter Seals is a national organization of outpatient rehabilitation agencies, including approximately 90 providers. AOTA is a professional association representing over 40,000 occupational therapists, many of whom practice in rehabilitation facilities.

The report recently released by the General Accounting Office, entitled "Medicare: Existing Contract Authority Can Provide for Effective Program Administration" is an excellent review of the system of intermediaries and carriers utilized by the Health Care Financing Administration (HCFA) for administration of the Medicare program. It makes the point that HCFA has adequate authority to make this system work to serve the ends of the Medicare program. Chapter 4 addresses the effect on contractor performance caused by reduced contract allowances from HCFA and suggests that these reductions, both in relative and absolute terms, are and will continue to have very adverse effects on the administration of the program.

The focus in the report is on the inability of intermediaries and carriers to perform proper medical audits and otherwise insure that the claims paid are those that qualify under the Medicare Act and regulations. From the perspective of providers, the impact of reduced allowances for intermediaries and contractors means poor performance in the processing of claims. This leads to confusion and frustration, which is compounded by HCFA's policies, both overt and covert, to deny or delay payments that should legitimately be paid. As discussed below, it is often difficult for a provider which is confronted by what appears to be dilatory and confounding positions on the part of intermediaries and carriers to determine if these are a function of inadequate funding or conscious policy on the part of HCFA. The effects are the same: slow or no payment and administrative obfuscation.

The Subcommittee is to be commended for undertaking this examination of the medicare contractor system and, specifically, the effect of such a system on the providers of services to medicare beneficiaries.

This statement is addressed to inadequacies of the system in processing and paying bills for services, primarily those for outpatient rehabilitation services. Before doing so, a few observations regarding inpatient rehabilitation services is appropriate.

We have reviewed the prepared statements submitted to the Subcommittee at its hearing on April 22, 1986. NARF, Easter Seal and AOTA support the positions of the American Hospital Association and the Healthcare Financial Management Association regarding the relationship between the processing of and payment of bills for medicare services and the Periodic Interim Payment System (PIP). Whether under cost reimbursement or prospective payment (which is based on past medicare cost reimbursement payments), medicare has not properly recognized the cost of working capital. In theory the need for working capital is addressed by the PIP system. However, PIP does not fully cover the cost of carrying billings in process and any further changes in the PIP or bill paying system of medicare are likely to aggravate this problem for

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inpatient medicare rehabilitation facilities.

More generally, medicare reimbursement rates do not provide profit margins to cover working capital requirements. Thus, any slippage in the payment of bills creates a financial gap which can only be filled from revenues from other patients, delayed payments to suppliers or diversion of reserves and contributions. Any of these is a subsidy of the medicare system by others -- a situation specifically prohibited by the Medicare Act.

The intermediary system used by HCFA to administer the medicare program is only a means to an end -- the provision of services and payment for such services. If payment is delayed or calculated in such a manner that providers are not compensated for their costs of delivering services, something has to give, and ultimately the losers are the intended beneficiaries of the program.

With regard to both inpatient and outpatient rehabilitation facilities, these effects are particularly acute, since rehabilitation facilities have a greater incidence of medicare patients than most other types of providers. Rehabilitation hospitals and units typically have 50% of their patient revenues covered by medicare, since the need for rehabilitation services among older patients is greater.

Turning to outpatient services (which are not covered by PIP), there is a fundamental flaw in the medicare payment system. There is no incentive in the system to pay bills promptly and accurately, nor is there any penalty for the failure to do so. The structure of the program presumes the good faith of HCFA and its intermediaries and carriers in dealing with providers of services. Thus, when HCFA or its agents choose to slow down payments to benefit the Medicare Trust Funds' cash position, to hassle a given type of provider or for other reasons, they are free to do so with little recourse available to the provider.

Intermediaries are encouraged by HCFA to delay or deny claims. The Hartford Courant, February 16, 1986 wrote:

> **HOME-CARE PATIENTS VICTIMIZED BY MEDICARE CUTS, CRITICS CHARGE**
>
> As far as Bena Dean is concerned, Christine Lunn saved her life.
>
> Last May, when Dean, a 69-year-old retired School guidance counselor, came home from the hospital after double heart-bypass surgery and a valve replacement, she had to be lifted out of bed. She was swollen and nauseated from her medication, and so weak she could not raise her hands.
>
> "I felt like I was going to die, really," Dean recalled.
>
> By the time Lunn's twice-weekly visits ended in September, Dean was down from 10 medications to four and could get around her house with a walker.
>
> Two weeks ago, during a random audit of Lunn's employer, the Visiting Nurse Association of South Windsor, a Medicare agent declared the government's old-age health insurance should not have paid Dean's $2,500 in home nursing bills. The reason given: She had not required "skilled" nursing care, which is the only kind Medicare covers.
>
> Dean will not be required to pay the bills. The Visiting Nurse Association plans to appeal the Medicare agent's decision.

This kind of retroactive Medicare denial is becoming common in the rapidly growing home health-care field, industry officials in Connecticut said. In its drive to contain costs they said, Medicare has become so restrictive that elderly patients may not be getting the care they need.

"If the average person opens up their little Medicare booklet explaining what's covered under home health care, they'd think they'd be able to get everything they want. It's just not the case," said William A. Dombi, a lawyer with Legal Assistance for Medicare Patients, a Willimantic-based legal advocacy group.

Home health-care agencies said Medicare has recently disallowed home health-care payments for:

* A man disabled by amyotrophic lateral sclerosis, a progressive, ultimately fatal muscular deterioration, who was getting seven hours of home health-care a week. Medicare said that, because his wife cared for him for more than 22 hours a week, he needed to be in a nursing home.

* A bedridden, senile and incontinent 84-year-old woman with terminal heart disease and severe osteoporosis, on the grounds that she did not need skilled nursing care.

* A patient receiving two daily visits from a nurse, on doctor's orders, to change the dressing on a large, open, draining wound, on the grounds that the care was medically unnecessary.

The crackdowns on home health-care costs comes at a time when Medicare is exerting heavy pressurs on hospitals not to admit Medicare patients except when absolutely necessary and to discharge them as quickly as possible....

Home health costs are also the fastest-growing type of Medicare payment. even though they still represent less that 3 percent of the total.

But almost from the beginning of this period of growth, the Health Care Financing Administration, the federal agency that runs the Medicare program, has been dismantling the home health benefit, Dombi said.

Part of Medicare's stepped-up supervision, he said, was in response to real abuses in the program -- agencies giving care to people who clearly did not need it. But in cleaning house, the government has gone overboard, Dombi said.

"I think it's the bottom line," he said. "The home care benefit is growing in terms of the Medicare budget... and they want to put a stop to it."

For their part, Medicare administrators denied any intentional effort to cut back home care, although they said supervision has been stepped up....
"It's the company's line that as Medicare intermediaries, we simply carry out the Health Care Financing Administration's regulations and are not acting on our own," said Marianne Sullivan, a company spokeswoman. "We're not in any position to explain the regulations, to defend them, or promote them."

In addition to the greater pace of auditing, Medicare has imposed strict new record-keeping requirements on the agencies.

In another article in the The Hartford Courant dated February 17, 1986:

> **FEDERAL AGENCY SETS QUOTA FOR MEDICARE REJECTIONS**
>
> WASHINGTON -- For every dollar the government pays health insurance companies to process Medicare claims, the Reagan administration expects them to deny at least $5 in benefits, according to federal regulations.
>
> The obscure rule for evaluating the performance of insurance companies hired by the Health Care Financing Administration is cited by critics as evidence the administration is trying to make it harder for elderly people to get Medicare to pay for post-hospital care.
>
> The regulation, which was formally adopted on 1982 and has been updated several times since, was detailed in a letter last summer to Rep. Edward R. Roybal, D-Calif., chairman of the House Select committee on Aging, from Lawrence J. De Nardis, acting assistant secretary of health and human resources.
>
> "Both medical review and audit are critical elements." DeNardis wrote of the cost-benefit ratio. "Failure to succeed in these elements could lead to various contract actions, including termination."
>
> No insurance company's contract has ever been canceled for failure to return $5 in savings for every dollar it earns. But critics contend that companies who get the lucrative audit contracts feel pressure to deny benefits with little regard to the merits of claims.

Hence the carrier in Connecticut is expected to deny a certain percentage of claims without regard for the validity of the claims and providers may not deal with the program with any confidence. Section 1898 of the Medicare Act, 42 U.S.C. Sec. 1395oo provides for the payment of interest on Part A claims which are disputed and decided in favor of the provider, but there is no provision in the Medicare Act for the payment of interest or other penalty for delayed payment of Part B claims.

It is clear from testimony received by the Subcommittee that HCFA has instructed its intermediaries and carriers to slow up payment of Medicare bills. It is also clear that intermediaries and carriers are being squeezed financially under their contracts with HCFA so that their staffs are being held constant or actually declining while the volume of work increases (See GAO Report, Chapter 4). This situation results in the failure to process bills from providers in a timely fashion. Since the effect is to reduce the flow of cash out of the Trust Funds, HCFA gets double duty from cutting contract payments to intermediaries and carriers. First, there are administrative cost "savings" and second, there are cash savings to the Medicare Trust Funds through deferred payments. This was acknowledged by Kevin Moley, Acting Associate Administrator for Operations, in his prepared statement for the Subcommittee's hearing on April 22 (see pages 6-7).

From a provider's viewpoint, it is difficult to distinguish between the effects of overt HCFA policies not to pay bills in a timely manner and the effects of inadequate staffing for intermediaries and carriers. Whatever the cause, the effect is the same -- big backlogs of billings and slow payments.

The failure of the Medicare program to pay for services in an efficient and timely manner falls most heavily on small providers with a significant volume of Medicare patients. As noted above in relation to inpatient services, rehabilitation facilities typically have a higher incidence of older patients because the services they provide are uniquely related to the needs of patients who have problems associated with aging.

Medicare's slow payment of bills has had a particularly adverse effect on Comprehensive Outpatient Rehabilitation Facilities (CORFs). There is a strong suspicion among CORFs that this is by design. The CORF benefit was added to the Medicare Act in the Omnibus Reconciliation Act of 1980 to be effective July 1, 1981. HCFA did not issue implementing regulations -- effectively suspending the effective date of the CORF benefit. Regulations were only issued on December 15, 1982, under the compulsion of a court order. The regulations and certification process present further roadblocks to qualification of CORFs, so that now there are only approximately 89 facilities qualified as CORF providers under medicare.

A great many of these confront a new obstacle with HCFA, i.e. the failure of HCFA intermediaries to process their bills and pay them. The reasons for such nonpayments are numerous, from 100% medical review (HCFA requires that every bill be examined), to intermediaries simply giving CORF billings low processing priority. When intermediary staffs are inadequate for the volume of bills being processed the latter is as deadly as the former. Letters from representative CORFs demonstrate this pattern:

1) From the American Rehab Center, Camp Hill, PA to NARF:

> Dear Ms. Zoller:
>
> Although it has been a while since we discussed reimbursement issues at the CORF conference in Washington, I thought it would be beneficial for you to receive a copy of the enclosed letter. We have been operational since September and continue to have significant problems in obtaining reimbursement from Blue Cross of Western Pennsylvania for our CORF claims.
>
> I would be very grateful if there are any steps that you feel would be beneficial for us to take in an effort to improve the timeliness of our payment from this fiscal intermediary. We continue to have cash flow problems and at present have an outstanding balance greater than 30 days with Medicare of well over $38,000.
>
> Thank you in advance for your response to this issue.
>
> Sincerely,
>
> G. Curt Meyer, M.S.
> Vice President of Operations

2) From the American Rehab Center, Camp Hill, PA to Blue Cross of Western PA:

> Judy Mill
> Provider Representative
> Provider Relations Department
> Blue Cross of Western PA
> 1 Smithfield Street
> Pittsburgh, PA 15222
>
> Dear Ms. Mill:
>
> I am writing to relate to you my deep concern regarding the mechanisms for payment to American Rehab Center - Camp Hill. As a health care provider in its infancy stages. [sic] Payment for service is essential in order to stay in business. We repeatedly need to call you at Blue Cross of Western PA to receive our Medicare payments during the last three months. I do realize that the Health Care Financing Administration has indicated that you should slow down your payments and that the volume generated from American Rehab Center - Camp Hill may not be significant compared to

other Comprehensive Outpatient Rehabilitation Facilities in the state. However, while we go through our stages of growth, we are in need of receiving payment as soon as possible from the fiscal intermediaries.

I would be very willing to meet with you at some time to discuss the means of improving this payment mechanism so that we would not need to continually call to inquire about payment.

Darlene Kauffman has indicated that you have been very helpful. We certainly appreciate that, however there have been several times when we haven't received payment, and we have been concerned about whether or not we will be able to meet our payroll. Clearly this is typical of a new organization that is falling within the norm of having cash flow problems. It would be very beneficial for us to improve our timeliness for payment with you so that we may stay in business in order to provide these services.

I would appreciate any communication that you have regarding these issues and look forward to hearing from you in the near future. Thank you in advance for your attention in this matter.

Sincerely,

G. Curt Meyer, M.S.
Vice President of Operations

3) From Commonwealth Rehabilitation Centers, Tampa, FL, to NARF:

Dear Ms. Zollar:

I have been requested to write and discuss the financial dilemma our CORF facilities have been confronting since organizing.

We initially began two years ago as Americare International, Inc. and began seeing Medicare patients since opening day.

The initial reimbursement from the Fiscal Intermediary was at 50% of charges and as you know, beginning a new business, it is literally impossible to meet cash flow requirements when you're being reimbursed at 50% of your charges. To add insult to injury, Blue Cross of Florida, our Medicare Fiscal Intermediary, was having difficulty in releasing payments to CORFs. By their own admission, "CORFs were a new concept, no one was sure of the regulations and to what extent payment should be made." Well, after a couple of months of this, our cash was exhausted. Several trips were made to Jacksonville to plead for an accelerated payment based on claims transmitted to the Intermediary.

The payments were granted, and while this was the short term solution, the accelerated payment technique was used several more times. In October 1984 we sent documentation to Blue Cross Blue Shield to increase the reimbursement rate from 50% to 80% and this was granted.

About this time, expenses were soaring, and while fiscal constraint was employed, it did not prove to be as successful as one might invision [sic]. Americare International, Inc. found itself in very deep financial trouble and Commonwealth Savings & Loan purchased Americare International, Inc. on August 15, 1985.

Commonwealth Savings & Loan established a wholy owned subsidiary called Commcare Health, Inc. which now owns and operates three CORF facilities, referred to as Commonwealth Rehabilitation Centers. Immediately after the acquisition many changes took place however the Intermediary was rejecting almost all of our charges for Social Work and Psychological Evaluations. In fact, not only were they rejecting these charges, but also holding up payments on the claims submitted within the same batch as the social and psychological charges.

To add fuel to the fire, on January 1, 1986 all Medicare providers were mandated to perform a 100% focused review on all CORF claims. Needless to say this has had a catastrophic effect on cash flow and claims processing. After 60 days and submission of over $100,000.00 in claims, we started receiving checks in the amount of $42.60, $61.20 and very few checks over $100.00.

Phone calls have been furious between the Intermediary and myself and I might add to no avail. I even made a special trip to Jacksonville with an accelerated payment request in hand, I was flatly denied. Not to mention Blue Cross had lost all of our transmissions from February 1 to February 15, 1986. The explanation given was that "their hands are tied" with the mandate of 100% focused medical review.

I question whether this will ever end, but certainly there should be some relief for the providers of quality service.

The bureaucrats are going to win, but I beg your involvement to intervene in this nightmare and seek a viable solution.

I will appreciate any and all assistance in alleviating this constant turmoil.

Sincerely,

John L. Newkoop
Director of Finance

While previous testimony in these hearings has focused on whether medicare providers should be paid within 30 days, the Subcommittee will note that these facilities are experiencing delays in payment measure in months.

NARF, Easter Seal and AOTA are aware of CORFs that have not been paid since August 1985. Others with outstanding billings of $38,000 to over $120,000 have not been paid since October despite repeated meetings with HCFA intermediaries. Many of these facilities have revenues under $750,000 a year and nonpayment totally disrupts their cash flow and ability to deliver services.

Furthermore, when a group of CORFs met with the intermediary in Region I in April 1986 to try to determine how to get bills paid, the intermediary told them that when they get a lawyer involved they (the intermediaries) slow the process even more. The reference to lawyers was to a letter written by NARF's general counsel at HCFA's request asking NARF to supply examples of specific nonpayment problems and how to remedy them. The net result for the facility in question is that payments have yet to be made and it has over $120,000 in outstanding bills. We find this form of retaliation by an intermediary absolutely reprehensible.

Putting the most favorable construction possible on these facts one must conclude that medicare intermediaries do not have sufficient competent personnel to handle their billings on a timely basis. Viewed from a more suspicious perspective, it appears that there is an overt effort to eliminate these providers. In any event, it is clear that in the absence of a positive incentive for HHS and its fiscal agents to make timely payments this situation will continue.

The Congress has, in fact, already provided such an incentive in the form of the Prompt Payment Act. This statute was enacted in 1983 to deal with the precise situation faced by many medicare providers, failure of the U.S. Government to pay its bills in a timely manner. The Prompt Payment Act, 31 U.S.C. 3901-6, provides that in the event a government agency procuring goods or services does not pay for such goods and services within thirty days after receipt of a proper invoice, it must pay interest to the provider of the goods or services at a rate determined with reference to the Contract Disputes Act. There is a 15 day grace period provided so that if the bill is paid within 45 days there is no interest penalty.

According to the prepared statement of Mr. Moley before the Subcommittee on April 22, 1986, the Prompt Payment Act does not apply to the Medicare Program; however, his statement does not contain any justification for this conclusion. By its terms, the Prompt Payment Act applies to "an agency acquiring property or services from a business concern." The definitions contained in the Act clearly bring the Department of Health and Human Services and, therefore, HCFA within the meaning of the term "agency" and the providers of services to the Medicare Program within the term "business concern." A review of the legislative history of the Prompt Payment Act indicates Congressional intent to provide a comprehensive remedy for the problems of business concerns doing business with the Government not receiving payment on a timely basis. NARF urges the Subcommittee to examine this question and elicit from HCFA a reason for its failure to observe the requirements of this law or, in the alternative, to start doing so.

Properly applied, the Prompt Payment Act would be a partial remedy for the problem of late, slow or no payment of medicare providers by the Medicare Program.

Whether through the Prompt Payment Act or by other means, it is imperative that the Medicare Program be given a clear and compelling incentive to pay claims in a timely manner. Its failure to do so jeopardizes the quality and availability of care to which Medicare beneficiaries are entitled under the Medicare Act.

When HCFA and its agents pursue programmatic and fiscal policies which impair the financial stability of providers, the effects are ultimately felt by Medicare patients. In the final analysis this means the loss or impairment of benefits to which Medicare patients have a legal right.

These are serious issues which deserve the Subcommittee's attention. The current fiscal situation and particularly the effects of the Gramm-Rudman-Hollings Act can only make them worse unless remedial action is taken.

John A. Doyle
Executive Director
National Association of
  Rehabilitation Facilities